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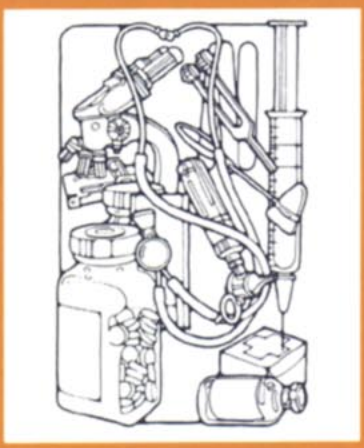

Medicine and the Welfare State

National Health Care: Medicine in Germany 1918–1945

The Coming Financial Collapse of Social Security

The Politics of the "Fair Share"

NOVEMBER 1993

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PERSPECTIVE

Voluntarism in Health: A Forgotten Solution

In a period of escalating medical and insurance costs, the working poor are faced with inadequate medical care. They are people who exist on the edge of poverty and live without government assistance. They are proud and self-reliant. . . .

The Bradley Free Clinic in Roanoke, Virginia, exists to meet the needs of our community's less affluent with respect and dignity. Our mission is to provide medical, dental, and pharmaceutical care to the Roanoke Valley's working poor using volunteer professional staff. We are one of some 140 free clinics across the country offering family practice medical care to indigent patients.

The success of the Bradley Free Clinic lies in voluntarism, a time-honored American tradition that is often left out of discussions on how to remedy our country's health care ills. Until the advent of Medicare and Medicaid in the early 1960s, numerous hospitals operated with the primary intention of providing health care for the disenfranchised. The Bradley Free Clinic and others like it have revived this forgotten method of providing health care for those unable to afford it. They have again made it possible for the medical community to care for the poor without the costs imposed by bureaucratic intervention.

Physicians have been extending solace to the poor for decades, usually in a very quiet, low-key fashion; they do not need or wish publicity for these activities. Most physicians, then and now, hold that helping the poor is part of their professional responsibility. Free clinics provide an excellent opportunity for physicians to continue to help the poor in a clean, well-run, clinically contemporary setting. Through the coordination of their services, the physicians of Roanoke have proven this to be true.

—JOHN M. GARVIN, M.D., writing in *Philanthropy*, published by The Philanthropy Roundtable

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The Kingdom That Gives Beethoven a C

What's happening in the world of arts subsidies says a lot about how modern governments are evolving. In the United States, there has been a contest between arts pressure groups and John Q. Public over subsidizing distasteful and pornographic art, and John Q. has lost. Across the Atlantic, in Great Britain, arts administrators are in the process of turning the whole theory of democracy upside down.

In Britain, the agency that doles out the subsidies is the Arts Council. Its music branch has developed quite distinctive tastes in composers, and it has decided to put taxpayer money where its mouth is. *The Independent*, a leading London newspaper, found that it had adopted a formula to simplify grant-giving, classifying composers into four grades.

At the bottom of the heap are the grade D composers who deserve no subsidy at all, old favorites like Johann Strauss and Edward Elgar. Grade C composers, a category which includes Beethoven, are worth a subsidy of only 450 pounds per concert. Grade B composers, including heavies like Mahler, merit 1,000 pounds.

Hitting the jackpot, at grade A, accorded a subsidy of 2,000 pounds sterling per concert, are Harrison Birtwhistle and Peter Maxwell Davies. These gentlemen are not rugby players or Arctic explorers. They are modern composers whose principal claim to fame is that the British public can't bear to listen to their music.

This grading system has upset concert organizers who naively supposed that it was their job to put on concerts that people wanted to come to, not stay away from. One promoter, Michael Blackledge, pointed out that he filled all 750 seats in Bedford's Corn Exchange when the concert featured politically incorrect Elgar and Delius, but that only 25 came when the approved modern composers were performed. He finds the grading system unworkable. "It's artistic interference with people on the ground who know their audience," he said.

Years ago, when the idea of massive arts subsidies was first proposed, arts insiders had reason to be worried. They were perfectly aware that what they were doing wasn't art as far as the general public was concerned. If democracy worked the way it was supposed to, they would be left off the gravy train. Voters would communicate their desire for likeable music to their representatives, and they, in turn, would tell the civil servants to give the public what it wants. Arts administrators, doing their democratic duty, would contrive subsidy programs boosting Viennese waltzes and leaving Birtwhistle and his chums down at the wine bar in the dustbin of history.

Fortunately for the insiders, none of this happens. British arts administrators don't suppose for a minute that they are servants of the people. Indeed, they have become quite self-righteous about their duty to give the public what it doesn't want. The music director of the Arts Council, Kenneth Baird, was not apologetic or embarrassed when asked about the policy of emptying concert halls with grade-A dissonance. "We are happy with these categories," he said. "It is our duty to support the new and most adventurous, given that that is the least likely to appeal to audiences and sponsors."

Somewhere between John Locke and John Major democracy got left in the dustbin. The modern state does not function, as the theorists hoped it would, to translate popular desires into policy. It has given rise, as the arts subsidy scene clearly proves, to a more or less insulated class of public officials who use the power of the state to implement their own prejudices.

We used to call this arrangement taxation without representation, and it used to make us angry. —JAMES L. PAYNE

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THE ECONOMIC WAY OF THINKING

PART 2

by Ronald Nash

In the first part of this eight-part series, we learned that economics is the basic study of conscious, purposive human behavior. We also learned that the unavoidable fact of scarcity in life requires human beings to rank the things they regard as important and then make choices. The subject of this month's essay is the fact that all economic valuation is subjective.

Objective Theories of Economic Value

Anyone who observes how human beings act in economic exchanges can easily see how various things are thought to have more value than others. It is natural to wonder about this fact. What is it about one thing that makes it more valuable than another? Why do people want some things more than others? Why are some things so valued that people are willing to make significant sacrifices in order to obtain them?

Until the late nineteenth century, economists and philosophers tended to regard economic value as *objective*. That is, the value of the economic good was thought to be inherent in some way in that which was valued. One of the most influential of these objective theories of economic value appears in the writings of Karl Marx. Marx believed that the value of a good or service is determined to a great extent by its cost of production. Suppose, for example, that all of the production costs (including the cost of supplies, labor, and everything else) to make a pair of shoes amount to $40. The value of those shoes (while new) then can never be less than $40, according to this view. The value here is objective in the sense that a number of factors, having nothing to do with human preferences and wants, have given those new shoes that value.

Marx and others set forth a labor theory of value which held that economic goods derived their value from the quantity of labor required to produce them. Thus, even the machines used to manufacture shoes were valuable because they were "frozen labor time."

A little reflection should quickly raise doubts about any theory that holds that economic value is inherent in the good or service. For one thing, consider how many

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DOVER BOOKS

At an auction, items sold can bring prices far above or below their original purchase price, depending on how important that item is to the people attending the auction.

times retail merchants end up selling for less than their cost.

I happen to be a stamp collector. About a year ago, I paid $3.00 for a recently issued U.S. stamp in a strip of three. The person from whom I purchased the strip of three coil stamps had paid 30 cents for them at the post office. Just last week, a similar strip of three stamps sold at an auction for over $100. What happened to make these stamps different was a set of tiny plate numbers that appear once every 50 or so stamps in a coil roll. In this case, stamps with this particular set of plate numbers have turned out to be extremely rare. What is the "true value" of stamps like this? Is it the 30 cents charged by the post office or the $3.00 charged by the retail merchant I dealt with or the much higher price at which strips like this are now traded? The simple answer is that the value of any economic good is no more and no less than what some individual will offer in exchange for it.

Another way to see the flaw in the belief that economic goods possess some intrinsic, objective value is to attend an auction. Items can bring prices far above or below their original purchase price, depending on how important that item is to the people attending the auction. The same principle is at work in the case of pawn shops and flea markets. Suppose one day that you are browsing through such a place and come across something that used to belong to your family; perhaps it is associated with important events in your childhood. Since the person who sold this object to the merchant may have not attached the importance it has for you, he may have parted with it for a few dollars. Because of the value you impute to the object you might, if necessary, be willing to pay several hundred dollars for the same object.

Or consider two diamonds of equal size and quality. Imagine that one is simply found on the ground by chance; no effort or danger was involved in its discovery. Imagine that the second diamond comes out of a diamond mine where an enormous investment has been made in building and operating the mine. The men who work in such mines have a difficult and dangerous job. And so we have two diamonds: one cost little or nothing, while the second was produced at enormous cost. Imagine next that our two diamonds happen to be offered for sale at the same auction. The two diamonds might easily sell for similar prices. What this shows is that the value of the two diamonds bears no relation to their respective costs.

At this point, someone might raise an objection to the conclusion I draw from the diamond example. My example illustrates the fact that value and cost are not necessarily related. But does it not show, my critic might say, that value still bears a relationship to the objective properties or characteristics of the thing? My example

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stipulated that the two diamonds were similar in size and quality. Does it not follow that their similar "value" reflects the fact that their objective characteristics are so much alike?

It is true that the two diamonds had similar objective properties. It is also true (in my example) that they sold for prices that reflect a similar value. In this particular case, the closely related prices only reflect the fact that two buyers placed much the same value on them; this might well have been a function of the objective features of the diamonds. After all, if two things are practically the same, they can be substituted for each other. The hamburgers I can buy at the McDonald's on the north end of town are indistinguishable from those I can buy from the McDonald's at the south end of town. Because they are so much alike, most potential buyers will treat them as equal in value. But the economic value is not inherent in the hamburgers any more than it is in the diamonds. The value is imputed to the thing by an individual valuer. Obviously, people take the objective features of things into account when imputing such value.

It would be a mistake to assume that just because two diamonds or two hamburgers sell for the same price, they must therefore be equal in "objective value." What two buyers are willing to exchange for an article reflects their separate personal valuation of that good. It is possible that two diamonds of different size and quality might sell for the same price. Any number of personal, subjective considerations might lead two buyers to offer the same price for goods with different properties. On the other hand, two similar diamonds might sell for different prices at auction, if buyers do not impute similar value to them.

In the last third of the nineteenth century several economists began to argue that economic value is entirely subjective; it exists in the mind of the person who imputes value to the good or service. If something has economic value, it is because someone values it; it is because that good or service satisfies a human want. The idea of imputation became central in economic thought.

The older, objective view of economic value tended to focus exclusively upon physical things and the ways humans sought to fulfill their purely material desires. It also gave inordinate attention to the role that money played in human efforts to bridge the gap between what people had and what they wanted. However, the subjective revolution in economics changed all this. Once economists recognized the personal and subjective ground of economic value, economists broadened their horizon to include all purposive human actions in their field of study. The scope of economics was expanded to include things other than money and material goods.

Many people value such things as truth, love, honor, friendship, virtue, and charity more than they value money, cars, clothes, and houses. Because such people rank truth, love, and honor so high in their personal value scales, their economic choices will reflect this ranking. The conscious, purposive actions of such people can be explained by economists who hold to a subjective theory of economic value. All the values a person holds affect the decisions he makes.

It is important to recognize that when economists state that economic value is subjective, they do *not* restrict the subjective ground of economic value to personal tastes. The fact that Jones and Smith impute different value to the same good does not necessarily reflect their differing tastes about the good. The value that people impute to things is also related to such factors as different information, different interpretations of information, different expectations, and different quantities they already possess. It may also reflect varying degrees of alertness to new opportunities. Far more is involved in the subjective approach to economic value than personal taste. But what is clear is that economic value is always imputed value.

A Religious Objection

Many religious people who are not economists find it difficult to reconcile claims that

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economic value is subjective with their conviction that value is always objective, absolute, and unchanging. Some might think that accepting the view expressed in this essay would commit them to believing that all values are relative and subjective. The fallacy in such reasoning should be obvious. Even if we should discover that *some* values (in one sense of the word *value*) are subjective and relative, it would not follow that *all* values are.

Much of the problem at this point arises from the fact that the word *value* is ambiguous. It may refer (1) to that which people do in fact value or (2) to that which people ought to value. We all recognize that many people value things that they ought not to value, and that they fail to value things that they ought to value.

We sometimes express the difference between these two senses of *value* by using the words *desired* and *desirable*. All that is required for something to be desired is for someone in fact to desire it. But just because something is desired, it does not follow that it is *desirable*, that it ought to be desired. In economics, value reflects the extent to which something is desired; it does not mirror that thing's desirability. Economists have ways of measuring the degrees to which people desire things; obviously, this is something quite different from attempting to measure how desirable it is. No matter how much people ought to desire something, the economic price of that thing will reflect only how much some individual is willing to pay for one additional unit of it. The price of an economic good reflects the extent to which individuals desire it; and this is something quite apart from the question of how desirable or worthy it is.

Religious people, whether they are economists or not, need to keep two things distinct. The first is the degree to which an individual may want X, a fact that reflects where X ranks in that individual's personal scale of values. The second is the need of individuals to alter the rankings in their personal scales of values to conform to what they ought to want. Christians, for example, are undoubtedly correct when they judge that their Scriptures oblige them to change the evaluations of themselves and others in order to bring them more in line with the evaluations stated in the Bible. While this task is clearly important, it is an activity that falls under a different heading than economics. Economic exchanges in the real world will mirror only the actual subjective value that individuals have imputed to the goods being exchanged. Any number of things, including conversion, may affect the way people rank things in their personal value scales. Whenever such a change in subjective value occurs, it will have an obvious impact on the judgments people make about the costs they are willing to incur to have one more or one less unit of some good. The result is that the array of goods produced and traded in the market will change as the personal value scales of individuals change.

The theory of subjective economic value does not imply that all economic choices are equally good in a moral or religious sense. Anyone is within his philosophical and theological rights to criticize particular economic choices. No defender of the market economy is required to defend all the goods produced by the market. It seems clear, therefore, that any objection to the theory of subjective economic value on theological or moral grounds is mistaken. In fact, it is from Christian theology that economics borrowed its central concept of imputed value. Telling people that certain values ought to be ranked higher in their preference scales is the proper task of the pastor, moralist, theologian, or spiritual counselor. The economist simply deals with how people do in fact make their choices with regard to the allocation of scarce resources.

Looking Ahead

Because of its importance, the notion of subjective economic value will be encountered repeatedly through the rest of our eight-part series. The ability of the reader to recognize these appearances will be an important sign of developing adeptness in the economic way of thinking. □

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National Health Care: Medicine in Germany 1918–1945

by Marc S. Micozzi, M.D.

Today we are concerned about issues such as doctor-assisted suicide, abortion, the use of fetal tissue, genetic screening, birth control and sterilization, health-care rationing and the ethics of medical research on animals and humans. These subjects are major challenges in both ethics and economics at the end of the twentieth century. But at the beginning of the twentieth century the desire to create a more scientific medical practice and research had already raised the issues of euthanasia, eugenics, and medical experimentation on human subjects. In addition, the increasing involvement of the German government in medical care and funding medical research established the government-medical complex that the National Socialists later used to execute their extermination policies.

The German social insurance and health care system began in the 1880s under Bismarck. Ironically, it was part of Bismarck's "anti-socialist" legislation, adopted under the theory that a little socialism would prevent the rise of a more virulent socialism.

By the time of Weimar, German doctors had become accustomed to cooperating with the government in the provision of medical care. The reforms of the Weimar Republic following the medical crises of World War I included government policies to provide health care services to all citizens. Socially minded physicians placed great hope in a new health care system, calling for a single state agency to overcome fragmentation and the lack of influence of individual practitioners and local services. The focus of medicine shifted from private practice to public health and from treating disease to preventable health care. During the German "economic consolidation" of 1924–1928, public health improved under new laws against tuberculosis, venereal disease, and alcoholism, with new advisory centers for chemical dependency and counseling bureaus for marriage and sexual problems.

Medical concerns which had largely been in the private domain in the nineteenth century increasingly became a concern of the state. The physician began to be transformed into a functionary of state-initiated laws and policies. Doctors slowly began to

Marc S. Micozzi, M.D., Ph.D., a physician and anthropologist, directs the National Museum of Health and Medicine in Washington, D.C., which recently brought from Berlin the exhibition, "The Value of the Human Being: Medicine in Germany 1918–1945," curated by Christian Pross and Götz Aly.

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see themselves as more responsible for the public health of the nation than for the individual health of the patient. It is one thing to see oneself as responsible for the "nation's health" and quite another to be responsible for an individual patient's health. It is one thing to be employed by an individual, another to be employed by the government.

Under the Weimar Republic these reforms resulted in clearly improved public health. However, the creativity, energy, and fundamental reforms found in social medicine during the Weimar Republic seem in retrospect a short and deceptive illusion. Medical reformers had wanted to counter the misery inherited from the first World War and the Second Empire on the basis of comprehensive disease prevention programs. In the few years available to the social reformers, they had remarkable success. But in connection with these reforms the doctor's role changed from that of advocate, adviser, and partner of the patient to a partner of the state.

Where traditional individual ethics and Christian charity had once stood, the reformers posited a collective ethic for the benefit of the general population. Private charity and welfare were nationalized. The mentally ill, for example, having been literally released from their chains in the nineteenth century and placed in local communities and boarding houses in regular contact with others (the so-called "moral therapy"), were returned to state institutions to become the ultimate victims of state "solutions."

With the world economic crisis of 1929, welfare state expenditures had to be reduced for housing, nutrition, support payments, recreation and rehabilitation, and maternal and child health. What remained of the humanistic goals of reform were state mechanisms for inspection and regulation of public health and medical practice. Economic efficiency became the major concern, and health care became primarily a question of cost-benefit analysis. Under the socialist policies of the period, this analysis was necessarily applied to the selection of strong persons, deemed worthy of support, and the elimination of weak and "unproductive" people. The scientific underpinning of cost-benefit analyses to political medical care was provided by the new fields of genetics and eugenics.

Genetics and Eugenics

At the same time as these economic and political developments, the application of nineteenth-century scientific discoveries began to make their way into twentieth-century public health and medical practice. Charles Darwin's studies on natural selection were of course based upon animal populations living in nature and not human populations living in complex societies. But the biological basis of natural selection gave rise to a concept of "survival of the fittest" in human civilizations. This term was coined by the British social anthropologist Herbert Spencer, and the concept led to "Social Darwinism."

Darwin's theories (developed in parallel with Alfred Russel Wallace—another British natural scientist) had been published prior to full elucidation of the principles of genetics. With subsequent understanding and acceptance of the science of genetics, the underlying basis of natural selection could more completely be described. While scientists still did not understand what made up the gene (awaiting Watson and Crick's discovery of DNA in the 1950s) they began to search for outward expression of inner genetic tendencies. In the absence of being able to pinpoint individual genes, they sought outward expression of genetic "types." These "typologies" were largely based upon external measurements of the body.

Much of this work was carried out by German anthropologists and physicians (often one and the same at that time) in newly acquired colonies in German East and Southwest Africa, prior to the loss of these colonies to Allied protectorates in World War I. Such work resumed following the war, however, and by 1927 the opening of the Kaiser Wilhelm Institute of Anthropol-

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ogy, Human Genetics, and Eugenics was celebrated in Berlin as the advent of the "German Oxford." The annual report of the Institute in 1932 stated: "The term eugenics means to establish a connection between the results of the studies in human genetics and practical measures in population policy."

Under the new "scientific understanding" of human biology provided by genetics and its implementation under eugenics, poverty, for example, would become merely an expression of degeneracy (*Entartung*) and genetic inferiority. "Inferior" and "superior" became natural terms used by persons of nearly all political persuasions, as readily as the terms "handicapped," "impaired," "socially dependent," or "disadvantaged" are used today.

Life Unworthy of Living

Following World War I there had been concern among some in Germany that the war had decimated the ranks of the qualified and strong while weak, unqualified, and inferior people had been spared. Many felt that scant resources should not be wasted on the sick and suffering. The philosophy of the unimportance of the individual in favor of the people (*das Volk*) led to the belief that individuals who had become "worthless, defective parts" had to be "sacrificed or discarded."

Alfred Hoche, a neuropathologist (as Freud had been) and Karl Binding, a lawyer, published a pamphlet in 1922, *The Sanctioning of the Destruction of Life Unworthy of Living*. Binding relativized the legal and moral prohibition, "Thou shalt not kill," and Hoche alternated between economic and medical arguments. Neurologists in Saxony formally discussed the topic, "Are Doctors Allowed to Kill?" A physician in Dresden pointed out "the contradiction that many persons (reformers) demand an end to the death penalty for crimes, but the same people are for putting imbeciles [*sic*] to death." By the time the National Socialist Party came to power in Germany, the mentally ill and the mentally retarded had begun to be sterilized and to be subjected to euthanasia in large numbers in German government institutions.

National Socialism and the Nation's Health

No profession in Germany became so numerically attached to National Socialism in both its leadership and membership as was the medical profession. Because of their philosophical orientation toward finding a more scientific basis for medical research and practice, government funding for research, and the practical benefits of acquiring university positions and medical practices from the many banned and exiled German Jewish doctors, many physicians supported Nazi policies. One of the first Nazi laws, passed July 14, 1933, was the "Law for the Prevention of Progeny of Hereditary Disease," intended to "consolidate" social and health policies in the German population and prohibit the right of reproduction for persons defined as "genetically inferior." After 1933, the connection between the theory and practice of politicized medicine advocated by many in Weimar Germany became actual in Nazi Germany.

A "Genetic Health Court" consisting of judges and doctors made decisions about forcible sterilization. As "advocates of the state," doctors prosecuted those persons charged with being "genetically ill" in sessions lasting generally no more than ten minutes and from which the public was barred. In 1935, an adjunct law allowed forcible abortion in such cases up to the sixth month of pregnancy. A total of 300,000 to 400,000 were sterilized and approximately 5,000 (nearly all women) died as a result of these operations. After 1945, it was argued to the Restitution Claims Commission of the German Bundestag that the "Law for the Prevention of Progeny of Hereditary Disease" not be considered in the same category as subsequent National Socialist race laws and other Nazi abuses. The sterilization law had been drafted earlier under the Weimar Republic as part of progressive health reform, and as late as

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1961 was defended by an expert at the Max Planck Institute on the basis that "every cultured nation needs eugenics, and in the atomic age, more so than ever before."

German Youth and Euthanasia

Following the sterilization laws, the National Socialists next implemented a strategy of euthanasia to solve the remaining problem of those whose conception and birth had preceded these laws. The pediatrician Ernst Wentzler, while developing plans to improve care in the German Children's Hospitals in Berlin, personally decided (as consultant to Hitler's Chancellery) on the deaths of thousands of handicapped children. Hans Nachtsheim placed delivery orders for handicapped children for his pressure chamber experiments on epilepsy. Joseph Mengele delivered genetic and anthropological "material" from Auschwitz to the Kaiser Wilhelm Institute and conducted his infamous twin experiments on the child victims of the Holocaust.

Julius Hallervorden at the Kaiser Wilhelm Institute for Brain Research at Berlin-Buch carried out several research projects based on euthanasia programs. Hallervorden and others systematically collected the brains of their patients who had been killed, taught the murdering doctors how to dissect, and cooperated closely with institutions where murdered children had previously been given thorough examinations and tests. During interrogation by an American officer in 1945, he stated, "I heard that they were going to do that . . . and told them . . . if you are going to kill all these people, at least take the brains . . . . There was wonderful material among these brains—beautiful mental defectives, malformations and early infantile disease. I accepted these brains, of course. Where they came from and how they came to me, was really none of my business." The collection was until recently kept by the Max Planck Institute (formerly the Kaiser Wilhelm Institute) in Frankfurt and used for brain research.

In a system in which so many were routinely condemned to die, the temptation proved strong to use human subjects in medical experimentation prior to their tragic and terrible deaths.

The Luftwaffe had developed aircraft which could climb to altitudes of nearly 60,000 feet, altitudes unattainable by Allied fighter aircraft. However, tolerance of these altitudes on the part of pilots had not yet been tested. Trials on volunteers at altitudes above 36,000 feet had to be discontinued due to severe pain. For this reason, lethal altitude experiments in pressure chambers were conducted on 200 victims held prisoner in Dachau concentration camp in a program called: "Trials for Saving Persons at High Altitude."

Many German ships were also being sunk in the North Atlantic and North Sea, and the same group of medical investigators conducted painful ice bath experiments on 300 Dachau prisoners in a research program entitled "Avoidance and Treatment of Hypothermia in Water." Other medical experiments were carried out with chemical and biological warfare agents and infectious diseases.

Following World War II much of this data was kept classified by Allied military authorities on the basis of national security. Debate continues to this day on the validity of these experiments and the ethical implications of any use of such data.

The Banality of Evil

We now know the end of this historical horror story of massive crimes against humanity and the leader of the thousand-year Reich burning in a bunker in Berlin. But it is not so easy to recognize the steps on the path down the slippery slope when we don't yet know the end of the story—as today we do not know which social health reforms in combination with which new medical technologies have the potential to plunge modern society over a brink in which disaster might result. Is legalized abortion a new form of medicide? Is doctor-assisted suicide a step toward positive euthanasia? Is modern genetic testing and the Human Genome Project the first step to a new eugenics? Is

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Dr. Robert Ritter of the German National Department of Health (right) and his associates carried out anthropological measurements and genealogical research. They prepared fingerprints and photographs in order to ascertain the "proportion of gypsy blood" in all of the Sinti and Roma of "Greater Germany."

Nazi medicine was implemented by a political-medical complex, a scientific and social philosophy imposed by a totalitarian regime.

FROM THE EXHIBITION, "THE VALUE OF THE HUMAN BEING."

health care rationing, which is always a result of government involvement in medical care, a step toward the new definition of "life unworthy of living"? Is our present "quality of life index" a new way of saying it?

Nazi medicine was implemented by a political-medical complex—on the basis of political health care—a scientific and social philosophy imposed by a totalitarian regime. It should never happen again, but could it ever happen again?

In the United States the medical profession operates in a mixed (not a national socialist) economy which does not yet have the institutionalized mechanisms of control and regulation of Weimar Germany—and in a democratic political system which thankfully does not have the political ideology of the Third Reich. But the "banality of evil" described by Hannah Arendt in the Third Reich may stem largely from a government bureaucracy in which 90 percent of the people think 90 percent of the time about process—not purpose. Does the modern bureaucratization of medicine hold any real risk for a possible return—with new health reforms and new medical technologies—to some of the horrors of National Socialist medicine? Removal of personal responsibility ("I was only following orders"), personal authority, and personal choice in a bureaucratized system may leave less and less room for individual ethics in the conduct of medical science and practice.

Politicized medicine is not a sufficient cause of the mass extermination of human beings, but it seems to be a necessary cause. The Nazi Holocaust did not happen for some inexplicable German reason; it is not an event that we can afford to ignore because we are not Germans or not Nazis. The history of Germany from 1914 to 1945 is a telescoping of modernity—from monarchy, war, and collapse to democracy and the welfare state, and finally to dictatorship, war, and death.

Medical ethics is the responsibility of all members of a society, not just doctors and scientists. Medicine and science alone do not have the answers to such questions as: When does life begin? When should it end? Are humans just the sum of their genetic parts or genetic programs? While bioethicists debate, individual medical choices are made a million times a day among doctors, patients, their families, and increasingly the government. The product of all these choices ultimately constitutes the ethical, legal, and social framework in which the practice of medicine and of medical research are conducted. In the end it is the preservation of freedom that will guide us to the best application of new health reforms and technologies in the future. □

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THE FREEMAN
IDEAS ON LIBERTY

MEDICINE AND THE WELFARE STATE

by Melchior Palyi

The essential idea of the Welfare State is as old as known history. Its concept and mechanism—the systematic dispensing, through political channels and without regard to productivity, of domestic wealth—were at the very core of the Greco-Latin city states, of the medieval city, and of the post-Renaissance absolute monarchy. In the city republics, ancient and medieval, it meant bloody civil wars. Their constantly recurring violent quarrels about constitutional issues disguised bitter class warfare to seize the power that was dispensing all benefits. Most of them went on the rocks of their internal struggles for economic privileges. A Lorenzo Magnifico in Florence or the Oligarchy of the Ten in Venice managed to "save" their cities—by grabbing the power and robbing the citizens of every vestige of political freedom and civic rights. Jacob Burckhardt's allegation that the orgy of paternalism under Emperor Diocletian resulted in governmental money recipients larger in number than the taxpayers, might be applicable to many other doomed civilizations.

France's Henry IV in the sixteenth century promised a chicken in every pot. Her brilliant Colbert in the seventeenth century and Prussia's enlightened Frederick the Great in the eighteenth, these forerunners of modern dictators, gloried in calling themselves the first servants of the nation. Their police state used the welfare state as its instrument, façade, and justification, as do modern dictatorships. In democracies the welfare state is the beginning and the police state the end. The two merge sooner or later, in all experience, and for obvious reasons.

The "mercantilist" princes of the sixteenth and eighteenth centuries developed the basic tenets of the modern welfare state in a piecemeal fashion. Originally their prime concern was the balance of trade—the want of gold and silver. To that, domestic policy was subordinated, except when political motives were uppermost, such as the fear of hunger riots which occurred time and again in England under the Tudors and Stuarts, forcing them to dispense humanitarianism. The craving for export surpluses led logically to promoting production. Amateurish welfare policies followed and soon became a determining factor in domestic politics.

The Welfare-Police State

In central Europe the eighteenth century was marked by the "Despotism of Virtue," exercised by benevolent rulers like Joseph II of Austria. The intolerance and intransigence of the "humanitarian tyrant" had no small role in provoking revolutions. The German *Kameralists* of the period, who taught the technique of civil government, developed systematically the blueprint of

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the welfare state (*Wohlfahrtstaat*) of a territorial scope, far beyond medieval city limits and as the heart of the police state (*Polizeistaat*). Even the words are eighteenth-century German. This tradition of bureaucratic rule—for the alleged good of the subjects—was the heritage taken over by Bismarck.

Bismarck's fundamentally significant role in modern history is rarely understood. His middle-of-the-road socialism was the connecting link between the old autocrats and the coming totalitarians. He thought he could overcome Marxism by his own brand of state socialism—just as Fabian socialists, Keynesians, and New Dealers profess that their middle-of-the-road statism keeps the totalitarian wolf from the door.

What Bismarck did accomplish was to revolutionize the old authoritarian school by giving it a quasi-democratic twist and by basing it on a superbly organized, technically well-trained, and thoroughly disciplined bureaucracy. His police-welfare (or welfare-police) state had firm roots as none had had before. The substance of a military monarchy was wrapped in a parliamentary cloak. Share-the-wealth popularity was to be dispensed legally by an all-powerful and efficient administration.

Welfarism in Operation

Even more interesting than to follow the historical records of the welfare state is to witness directly its contemporary gyrations and its ties with other facets of public policy. This writer was "conditioned" to the problems by early acquaintance with the petty inside-politics in the welfare monarchy of the Habsburgs. His conscious interest dates back to his studies in German universities from 1910 on, when the great masters of the German Historical School still were exerting intellectual leadership. The German public, and most Europeans for that matter, stood under the spell of Bismarck's forceful personality, without realizing where that spirit was leading. The intelligentsia was infatuated already with the then still misty ideal of the welfare-dispensing Iron Power. So was the populace on the street.

Otto von Bismarck
(1815–1898)

It was my good fortune, in particular, to come in close contact, as their student and assistant, with the two most original thinkers and most brilliant personalities of the period: Lujo Brentano and Max Weber, the foremost social scientists of their age. They were scholars of encyclopedic scope and of statesmanly stature, animated by the ethos of their belief in liberty and justice. As true liberals, they stood in matters of labor policy for trade unionism, the eight-hour day, and for factory legislation, as far as compatible with domestic free enterprise and international free trade. They were opposed to dogmatic laissez-faire—which meant paternalism in labor relations—as well as to paternalism in government. Realizing that history is the record of the eternal battle between the power and the people, they saw clouds rising that most of their contemporaries ignored: the aggressive economic nationalism and the congealing, overbearing bureaucratism of the Neo-Welfare State. They saw the unique part Bismarck's Second Reich played in the revival of authori-

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tarianism and fought it as a threat to the progress of occidental civilization.

As early as 1881, Lujo Brentano warned that adventuring into governmentalized medicine is the first step toward the Neo-Welfare State, which in turn opens up a road to national catastrophe—in the long run. The run was too long and too slow to be understood. Other more urgent problems occupied our minds. The warning was practically forgotten by 1919 when I gave my first courses as an instructor at the Munich Graduate School of Commerce on Insurance and on Cooperatives. Compulsory medicine seemed to be well established and a minor problem. In-between years, spent on (unfinished) medical studies, provided no inkling of its practical functioning. The prevailing academic pattern naively accepted a governmentalized pseudo-insurance as a chapter of *Sozialpolitik* (welfare policy), differing from other insurance only by its non-profit character. And it was defended as an alleged necessity in industrial society.

Intermezzo

We were preoccupied with the Versailles treaty, the great inflation and domestic and international reconstruction, and the sweeping out of the moral and material debris left over by Ludendorff. Europe's fatal fourteen years of transition after World War I began under the Lenin nightmare and ended with the Hitler chimera. True liberals were driven into an unholy and futile alliance with the middle-of-the-roaders.

After years of experience and study in international banking and public finance, I began to see that what most of my academic colleagues accepted and defended as an accomplished fact, the Bismarckian social insurance, was worm-eaten at its very roots. What have "high finance" and international affairs to do with the poor man's compulsory social insurance? A great deal, as I found out, and with more than finance. For one thing, the social insurance funds gave the welfarist Weimar government a dangerous foothold in the nation's capital market and taught it to grab for other footholds.

For another thing, I stumbled upon the discovery that German compulsory medicine was more expensive than private health insurance and gave less in exchange. On top of that, it was badly infected with corruption.

Insight into some of these shortcomings came about through my friendship with an outstanding socialist leader, old Eduard Bernstein. He was one of the three or four early apostles of the Marxian creed. But he lacked the fanatic dogmatism of the others. He became famous by speaking out in the 1890s what every Marxist knew and none dared to say—that history was not marching according to the time-table of the class-warfare theory. For this, he was temporarily ostracized by his own party. Through his honest eyes, I began to see that everything was not in order in the medical Utopia. The more I looked into it, the more disquieting the picture became.

From Weimar to Hitler

The welfare state was moving into the great depression. My work at the very center of German and international banking put me at a vantage point from which to observe closely the world-wide growth of Welfarism. It was intimately tied up with the political scene of the 1920s, with its global money management and fictitious pacifism. It was supported by monopolistic wage structures, governmentally promoted international cartels, inflated gold exchange standards, by a centrally manipulated capital flow on the one end and by reckless spending on the other. It had to break down sooner or later.

In many ways Hitler's rise was startlingly revealing. That one-third of the otherwise sober German people voted Nazi, and over 10 percent Communist, was bad enough. But what about the rest, the three or four *bourgeois* parties and the Social Democrats? Why didn't they resist instead of letting the power slip without a single shot into the hands of notorious gangsters? The Social Democrats and the trade unions behind them constituted the world's

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oldest, largest, best organized, and most intelligent labor movement. Why did they surrender shamefully and let themselves be disarmed?

The Weimar Republic catered to the trade unions and raised the wage level artificially, at the same time bestowing subsidies and high tariff protection on the heavy industries and the big landowners, the Prussian *Junkers*. Once a nation is entangled in the meshes of the welfare state, the demagogue who can draw out of his hat more welfare for more people has every chance in a crisis. The Bismarckian paternalism could be turned into Ludendorff's planned economy by a mere switch of the bureaucratic gear, which then could be shifted without grinding into the welfare state of the Weimar Republic. As that got into trouble, the ultimate of demagoguery, the combination of ultra-nationalism and super-welfarism, had a field day. By that time, the socialists as well as the middle classes were so intoxicated with the ideas of an allegedly inevitable state paternalism that the moral fiber had become too weak to generate resistance.

Humanitarians in Disguise

Perhaps the most spectacular "social" aspect of Nazism was its emphasis on nationalism. That was not accidental. The health, or rather sickness, propaganda employed by Bismarck elevated that aspect of social welfare to a prime political issue. Just why were such ruthless men as Bismarck and Hitler so profoundly interested in the physical well-being of their subjects—and in high birthrates!—while totally indifferent, nay, inimical to their mental integrity! But after a fashion so were their predecessors in the Mercantilist age, especially the ministers of the imperialistic Bourbons and the power-lusty Hohenzollerns. And so are their successors to this day.

Evidently, more than humanitarianism was at stake. Watching the world-wide growth of compulsory health insurance, from Icelandic fishermen to coal miners in China, I noticed something that seemed to be overlooked: that all modern dictators—Communist, fascist, or disguised—have at least one thing in common. They all believe in social security, especially in coercing people into governmentalized medicine.

A *selected list* of men who have claimed credit for, or have been credited with, introducing or strengthening and expanding governmentalized medical care reads like an extraordinary Who's Who:

Prince Otto von Bismarck, Chancellor of Germany (1884);
Franz Joseph I, Emperor of Austria (1888);
Franz Joseph I, King of Hungary (1891);
Wilhelm II, "the Kaiser" of Germany (1911);
Admiral Miklos Horthy, reorganizing the scheme as Regent of Hungary (1927);
Nicholas II, Czar of Russia (1911);
Vladimir Lenin-Ulianof, founder of modern dictatorship in Soviet Russia (1922);
Joseph Stalin-Dzhugashvili, almighty Prime Minister and dictator of the U.S.S.R.;
Joseph Pilsudski, Marshal and para-dictator of Poland (1920);
Alexander I, King and dictator of Yugoslavia (1922);
Antonio de Oliveira Salazar, the professor-dictator of Portugal (1919 and 1933);
Benito Mussolini, Prime Minister and the Duce of Italy (1932 and 1943);
Francisco Franco, military dictator of Spain (1942 and 1945);
Yoshihito, Mikado of Japan (1922);
Hirohito, Mikado of Japan (1934);
Carol II, pseudo-constitutional King of Romania (1933);
Joseph Vargas, President and would-be dictator of Brazil (1944);
Juan Perón, President and boss of the military *junta* of Argentina (1944);
Adolf Hitler, Chancellor, the *Führer* of Germany (1933, etc.);
Pierre Laval, Prime Minister of France (1930), later executed for his fascist activities;
Ambroise Croizat, Communist Minister of Labor in France (1945);
Georgi Dimitrov, the late chief agent of the global Comintern, Premier of Sovietized Bulgaria (1948);

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Josip Broz, alias Tito, Prime and Foreign Minister, dictator, general secretary of the Communist Party of Yugoslavia (1947);
Boleslaw Bierut, President and dictatorial figure-head of Satellite Poland (1947);
Klement Gottwald, President of the Sovietized Republic of Czechoslovakia (1948).

This list of power dynamos—or symbols of power—with bleeding hearts for human suffering is by no means complete. Complete data on some of the Satellite and Latin American bosses are not available. Some others are missing because they do not qualify technically for membership in the club of recognized full and semi-dictators and of paternalistic rulers "by the grace of God" or otherwise, having been elected in ordinary democratic procedures and still exposed to new elections. But who would have foreseen that an easy-going, money-grabbing politician like Laval was to become a sort of second-hand Mussolini? Most certainly Laval claimed and wielded, about 1930, less than a fraction of the discretionary and arbitrary power the British Health Minister wields at this writing. And there are more Pierre Lavals and Aneurin Bevans around in what we call the democratic world than the unsophisticated might assume. They manage to be re-elected again and again and strive to rule by blank delegations of power, immune from judicial controls and supported by rubber-stamp parliaments typical of "advanced" welfare states of twentieth-century vintage.

Socialist Nationalism

Indeed, out of the ashes of the welfare states that went down unsung in the tumultuous depression new and much more imposing ones have risen since. It seems that history is running in cycles, progressing from what is known as National Socialism to what is recognized as Socialist Nationalism.

Ever since Bismarck, great dictators and little demagogues compete with one another and with the humanitarians in courting the favor of the ailing, the lame, the blind, the poor, the underprivileged, and the aged. In World War I, Ludendorff used Germany's social insurance, then Europe's most "progressive," for propagandizing Teutonic social and cultural superiority. Today, British and French propagandists vie with each other in eulogizing the respective security plans. But Stalin outdoes all of them. "Government insurance in the U.S.S.R. is a source of pride of the Soviet workers before the whole world. It is one of the jewels in the colossal edifice of Socialism. It is one of the testimonials to *Stalin's deep solicitude for his fellow men* by which we are all warmed and heartened," said *Trud*, the organ of the Soviet trade unions, in 1937.

The great French visionary, Alexis de Tocqueville (*De la Démocratie en Amérique*, 1840), warned more than a century ago that democracies like ours may succumb to a new and soft technique of governmental benevolence that subdues all individuality. The suspicion that the solicitude of notorious tyrants for the welfare of their subjects must have something to do with the political nature of the medical security systems was one consideration that inspired this study.

From Bismarck to Lenin: Origin and Rise of Compulsory Medicine

Obligatory health insurance started moderately enough—in Prussia. Compulsion under a law of 1845 was left in the hands of municipal administrations, with no government subsidy involved, and no contributions from employers. The anti-socialist law of 1878 suppressed many of labor's voluntary associations for sickness benefits. The next step was the governmentalization of the associations' functions.

It was no mere accident that the ideological forefathers of Nazism, Adolf Wagner and Eugen Dühring, happened to be the "brain trusters" behind Bismarck's "nationalistic socialism to end international socialism," using his own terms. When, on January 1, 1884, his compulsory sickness scheme went into operation it literally started a new era—a new age in the history of welfarism.

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Bismarck's role in modern history is rarely spoken of nowadays. Undoubtedly, his political and administrative "genius" has shaped history down to our times. His revolutionary innovation in welfare policy was preceded five years before, in 1879, by the imposition of a protective tariff that started Europe's internecine commercial warfare which endures to this day. And it was followed by the introduction in 1889 of universal military service covering even the middle-aged manhood. This started a rearmament race leading into total wars with the objective of annihilating entire nations.

The shrewd Iron Chancellor—the dictator in constitutional disguise, quoting M. J. Bonn's epigram—meant to kill several birds with one stone when he embarked on his program of appeasing labor. The reason, announced in the November 17, 1881, message of Emperor William I, to offer something positive to labor, not merely the repression of socialists by police force, may have been born of genuine worry over the unrest of the working classes due to the long depression that had engulfed Europe since 1875. But the true motive has been pointed out in the penetrating Bismarck biography (Vol. III, pp. 370–371) of Erich Eyck: "To his mind the State, by aiding the workers, should not only fulfill the duty ordered by religion, but it should obtain in particular a claim on their thankfulness, a gratitude that was to be shown by loyalty to the government and by loyal pro-government votes in elections." In other words, it was the old-fashioned attempt of the monarchy to ally itself with the *plebs* against the "aristocracy" in between the two. However, the social insurance legislation did not stop the Marxists from returning in increasing parliamentary strength. The attempt to subdue the socialist movement by appeasement ended in a political fiasco.

Prince Bismarck found other satisfaction. The state socialism of His Highness was directed against the business interests and Liberal (free trade) Party. The latter had accepted the principle that workers should be forced to insure themselves but stood for their freedom to choose their own, non-governmentalized agencies. What was even worse from the militarist point of view, the Liberals were blocking time and again the Chancellor's requests for armaments. The Reich he created had almost no revenues of its own other than from import duties and excises. It had to rely on contributions from the states which were available only through unpleasant parliamentary procedures. The new social insurance organizations were to place their resources at the federal government's disposal, saving Bismarck the embarrassment of going, when need arose, with his hat in hand to a reluctant Reichstag.

Above all, the new system was an offshoot of his economic and political philosophy. Bismarck was a tradition-bound reactionary, altogether resentful of modern industrial development, although he himself owned a small paper mill. As did many of the ultra-conservative contemporaries of his *Junker* class, he trusted agriculture and handicraft but frowned on large-scale industrial enterprise and on trade unionism. To check both, if they had to be tolerated, was one of his goals. Governmentalizing and thereby controlling, through an appropriate bureaucratic apparatus, the providing of medical, accident, and old-age care and of death (burial) benefits seemed an obvious way to put the reins on laissez-faire capitalism as well as on labor.

The Spread of the Idea

This approach conformed to the paternalistic make-up of his mind—as it conforms to the paternalism of modern dictators and of humanitarian social workers. It is no mere accident if pseudo-liberals bubble over with praise of the arch-reactionary Prussian *Junker*'s medical security legislation. It was especially palatable to the bureaucracy of the Habsburg Monarchy.

The West resisted at first. It still was imbued with the nineteenth-century tradition of individual freedom and responsibility. But even before World War I its resistance began to soften under the fascination of the power emanating from Wilhelminian Germany and under the German propa-

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ganda that labor's patriotism has to be bought by social concessions. Shortly before or during that war, Britain, Norway, Iceland, Russia(!), etc. introduced modified replicas of the German compulsory panel system, followed by more countries after 1918. A dead and defeated Bismarck proved to have a wider spiritual influence than the living and victorious one ever enjoyed.

The triumphant march of authoritarian medicine received a fresh boost at the outset of the great depression when, among others, France, after a decade of political oratory and wrangling on the subject, instituted a system of its own. It was modeled on the German but with significant modifications.

However, 1943–46 was the most crucial time since 1881–84 in the Western history of compulsory health service. It was the hour of the liberation from Nazi occupation, with the parliamentary systems of the liberated nations in a semi-chaotic condition, and with Communists either in cabinet posts or having decisive influence in public affairs. As a result, far-reaching legislation was hurried through, which under normal conditions, would have run into serious obstacles. In France, in November 1944, a new social security law of communistic coloring was voted in a virtually empty Chamber of Deputies. Left-wing rule in Belgium was responsible for its sickness scheme of 1944. It was also under abnormal wartime and post-war conditions that Italy and Holland "reformed" their sickness plans. New plans were put into operation or the old ones were revamped thoroughly in Australia, Argentina, Brazil, Chile, Spain, the Russian satellite countries, Costa Rica, Ecuador, and of course in Britain. Legislation has been passed, but is not as yet in effect in three Canadian provinces and in Sweden.

Hitler, the Humanitarian

It is a fact, and a very remarkable one, that the great demagogues of our age appear to be greatly worried about the health of their subjects. No one was more so than Adolf Hitler. His racism was the last word in "biological" demagoguery, unless the new anti-hereditary biology of the Soviets exceeds it, an expression of the identical nationalistic purpose. In terms of political results, it was a most effective demagoguery due to its emphasis on health and virility. As a committee report on health insurance of the Canadian House of Commons put it (March 16, 1943): "During the early years of Hitler's regime, the government's medical program was looked upon by many observers as one of the greatest props of the totalitarian state."

Before coming to power, the Nazis were violently critical of the social insurance set-up, considering it a weapon in the hands of their enemies, the Social Democrats. They objected especially to the extravagance and corruption in compulsory medicine and to its alleged effect in "softening" German manhood. Thereby they earned the applause of doctors as well as of businessmen and the approval of the disgruntled middle classes. They promised thoroughgoing reform and drove their opposition home so forcefully that Chancellor Brüning was constrained to introduce in 1931–32 several measures affecting the medical care system which were most unpopular with labor. A three-day waiting period before cash benefits became available was made mandatory. A small tax ("deductible") on prescriptions and a levy of 50 *Pfennigs* on each quarterly sickness ticket of the patient were imposed. This charge of 20 cents in American money per quarter, imposed on patients many of whom were unemployed, resulted at once in cutting the number of applications by about one-quarter! But these "deflationary" measures, together with the liquidation of the totally bankrupt unemployment insurance, also had the consequence of arousing an ill-feeling among the workers which had no small influence in bringing down the house of the Weimar Republic. Brüning took the blame; Hitler got the credit.

Once in power, the latter soon reversed his strategy. The ill-famed Dr. Ley, boss of the Nazi labor front, did not fail to see that the social insurance system could be used for Nazi politics as a means of popular

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demagoguery; as a bastion of bureaucratic power; as an instrument of regimentation, and as a reservoir from which to draw jobs for political favorites and loanable funds for re-armament. Brüning's extra tax on panel patients was cut in half. By 1935, with Hitlerian full employment under way, the few pennies of extra tax represented a purely nominal charge. The sting was taken out of it.

The *Führer* gained in popularity by reducing to negligible proportions an unpopular measure which he himself had instigated. He lost no time in making a positive contribution of his own to the organization of compulsory medicine by extending it in 1939 to small business (handicraft), by tightening it in Austria (1938), and by establishing compulsory health care in occupied Holland (1941). One of his last "social" measures, in March 1945, was to have workers in certain irregular types of employment included. But his attempt to abolish the autonomy of the panels and to regiment them by centralization had been checked by the concerted resistance of the medical profession, the panel bureaucracy, and public opinion. Similar abortive attempts at complete bureaucratization of the panels were made under the Kaiser in 1909 and in the Weimar Republic's revolutionary days in 1919. The same goal is on the Social Democratic Party's agenda again in 1949.

Of all totalitarians who have written their names in the book of medical economics and politics, Lenin's will have to be printed in the largest capital letters. His was (1917) the first complete cradle-to-grave plan, the first plan embodying complete nationalization of medicine. His influence on the West did not make itself directly felt until World War II. Since then, wherever Russian bayonets take over, the Soviet blueprint of social security follows. Even more important to us is his ideological influence, embodied in the Beveridge Plan of 1943, that in turn appears to be spreading over Western Europe, Latin America, and the Antipodes.

Lenin and Bismarck had in common the paternalistic philosophy of government which included the supremacy of a trained and solidly disciplined bureaucracy over what they both considered the anarchy of the unregimented marketplace. To both, the "little man" was either financially or at any rate morally incapable of caring for his own future. Both were motivated by an insatiable thirst for power and utilized to their own political advantage the alleged responsibility of the State for controlling the insecurities of industrial life. Social insurance or social security was essential to their concept of the Good Society. It involved a regimented society ruled by their own superior wisdom.

From Social Insurance to Social Security

Actually, Lenin and his followers were thoroughgoing admirers of the Prussian bureaucracy. Soviet planning was built, at the outset, on the pattern of German military management in World War I. But there the ideological community of the two authoritarians ended. Bismarck presented his project in the name of the Christian idea of the state, confusing it with the state idea of eighteenth-century enlightenment. (His much vaunted "Christianity" did not interfere with Bismarck's violent opposition to any sort of factory law, such as to enforce minimum hygienic requirements.) Lenin was a genuine revolutionary, basing his Communism on a purely materialistic philosophy. To the one, private ownership of the means of production was sacrosanct but was to be regimented; for the other, it was to be wiped out altogether. Bismarck had to compromise with resisting parliamentary forces led by the industrialist Stumm. Even the trade unions were opposed tooth and nail; they could not foresee—nor did Bismarck, of course—that some day they themselves would have the power to use the scheme for more power. Lenin, by 1922, having wiped out parliamentary resistance, possessed power absolute as no sovereign has had since Genghis Khan.

Two basic types of governmentalized medicine resulted. The Prussian bureaucrat created the obligatory health insurance of a comparatively limited scope. What the Rus-

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sian Bolshevist has bestowed might be described as compulsory health security of an unlimited medical orbit. Perhaps they should be distinguished as governmentalized vs. socialized medicine. In the one, the beneficiaries are "insured"; in the other, they are "registered."

That social insurance à la Bismarck and social security à la Lenin are different in degree only—that the dynamic potentials of the one tend to carry over into the other—may astonish those who do not realize that Bismarck's famous "personal rule," that was to wreck his nation's democracy, was a conscious if abortive attempt aiming basically at the same political goal which was to materialize in the Politburo (and in Hitlerism).

Lenin vs. Bismarck

Bismarck's system meant to be, in appearance at least, what its name indicated: insurance, even if without a true actuarial foundation, and a subsidized, involuntary plan. At the outset, the insured were to be classified according to risks and to receive cash benefits in proportion to their contributions; a surplus, the equivalent of profit, was to be accumulated as an emergency reserve to guarantee the insurers' (panels') solvency; each type of risk incurred was to be offset by appropriate premiums; preferably, the risks were to be distributed by re-insurance; etc. These are axioms of sound insurance management, most closely approximated at present by the Swiss panels among European cooperative systems of medical care.

Nothing of the kind is aimed at in the Bolshevist pattern, the all-embracing program of Comrade Lenin. The same holds in principle for the compulsory set-ups based on Leninian security ideals now in operation in France and Britain. There, too, the pretense of businesslike management has been almost totally abandoned.

Bismarck's humanitarianism was limited originally to the worker dependent on hourly wages. Thus the range of persons falling under the compulsion was defined. This type of legislation, which still predominates on the Continent, restricts panel membership to employees and their families, or to the "economically weak" groups comprising the income brackets not above skilled factory labor.

In Lenin's kind of world there is, supposedly, one kind of income recipient only. All are in the same boat; all need the same support. The idea of medical insurance for the underprivileged is inflated into equal medication for everybody. Every one according to his needs is the underlying axiom. From a humanitarian device of restricted confines, the idea has grown into all-embracing, Communistic dimensions—on paper. In reality, the industrial population only is "secured."

In Soviet Russia, from 1922 to 1938, nationalized industry—i.e., the government—carried the cost of socialized medicine in the form of a 6.5 percent "payroll tax" (25 percent for all social security) with recourse on the national budget to cover eventual deficits. Industries, not labor, were to pay the bill. Similar systems with minor modifications are now being set up in the satellite countries. In the 1948 Bulgarian scheme, for example, the self-employed are the only ones to pay contributions—which is one way to hasten their elimination—with all benefits of medical service freely dispensed to everyone.

Of course, Lenin's promises and Stalin's practices are worlds apart. Since 1938, the trade unions, the workers, had to take over about 8 percent of the total cost. Hazard-classes were re-introduced, and the contributions graded accordingly. Medical benefits have been greatly deflated, while the number of persons covered has risen fourfold in the decade since 1928. And the Soviet health plan has developed into a forceful method of disciplining labor. Cash benefits to adult workers, for instance, are available only at the rate of 50 percent of their wages after two years of uninterrupted work in the same industrial unit; 60 percent, 80 percent, and 100 percent accrue if they stay three, six, and more years, respectively. Motherhood benefits are guaranteed by the Soviet

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constitution but are paid only to women who have worked at least seven months in the same plant.

But the aristocracy of Soviet officialdom and labor receive all the sickness care their country is able to give, including richly endowed sanatoria and rest-homes in the Caucasus and the Crimea. And Stalin claims credit for being the Great White Father dispensing health security to all of his subjects.

Minimum or Maximum to Be Provided?

After World War II, Western Europe's medical schemes were not revolutionized by open adoption of Lenin's plan. But the latter gave a tremendous impetus in a direction that has been under way ever since Bismarck. The original German set-up was meant to be, to repeat, health "insurance." The weight of the entire scheme rested on cash benefits per day of lost income. Benefits in kind—medical services proper—were supplementary only, largely left to the decision of the individual panel which had a broad autonomy in disposing of the means on hand, even in determining the percentage levy on payrolls. The emphasis on cash benefits and on the autonomy of the panels was a basic feature of that original plan wrested from Bismarck by the Parliamentary opposition.

It did not take two decades to reduce to a fraction of the total the share of cash benefits in the disbursements of the German panels. Once services in kind become the mainstay of the sickness scheme, it turns into a queer instrument of wealth redistribution. (All other branches of social insurance, with the partial exception of workmen's compensations for accidents, are restricted to cash disbursements.) Contributions cease to bear any relation whatsoever to the risk involved. Policing by physical controls over a most vital sector of private life takes the place of actuarial calculation.

Thus, the difference between the Bismarckian and the Leninian patterns tends to fade out. But still, the contrast between the old and the new approach reaches into every corner of the problem. Paternalistic as the Bismarckian scheme was, it did not intend to free the individual of all responsibility. He or she was to be secured to the extent only of absolute necessities. An irreducible minimum of health care and of income guarantee was to be dispensed, no more. Accordingly, cash benefits had to be much smaller than the actual income of the recipient when working. Medical services were to offer as much as was objectively necessary to restore health; but the patient was not to be pampered, and his incentive to care for himself and for his family was not to be impaired.

The postulate of economic self-reliance in spite of compulsory "insurance" permeates all medical schemes built on the Bismarckian pattern. The beneficiaries are supposed to carry a major share of the costs by their own contributions and partly also by "deductibles." As to disbursements, they should be kept at a minimum by thrifty administration of the panel and by sharp control over its spending. Otherwise, there is to be no interference with medical practice. In short, business-like management is the *idea* of compulsory insurance proper, presupposing business-like units to do the job in a decentralized, more or less competitive fashion, if under supervision by the authorities.

The latest editions of the Welfare State abandon the misleading claim of offering a system of insurance which would imply some sort of *quid pro quo* between premiums paid and benefits received. In medicine, instead of providing the barest minimum, it promises the desirable maximum. Its objective is to fulfill a social function; the emphasis in lip-service is on what the State allegedly owes its citizens. The security organization is centralized; its administration tends to be fully governmentalized. Ultimately, all medical personnel is to be nationalized, as we shall see. □

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THE FREEMAN
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What Hunger Insurance Could Teach Us About Health Insurance

by Joseph Bast

To understand what lies at the heart of the failure of our current health-care financing system, imagine, if you can, what the world would be like if we tried to buy food the same way we buy health-care services.

You could go to work tomorrow morning and hear your boss tell you the following: The company has decided to offer a new benefit: hunger insurance. The company will purchase a hunger insurance policy for you that covers about 95 percent of your food costs whenever you enter a grocery store or restaurant, and a smaller share of the miscellaneous snacks and condiments you purchase from street vendors and the corner drugstore. To pay for the new benefit, the company will withhold some of your pay—about $100 a week or so.

Effect on Consumers

What effect would hunger insurance have on you, a *consumer* of food? If you're like me, you will probably start to eat more . . . and eat better, more expensive foods. Why eat hamburger when you can have tenderloin? Why settle for beer when the finest wines cost *you* just as little? Why eat at McDonald's when you can eat, for nearly the same price, at Chez Paul?

If there were such a thing as hunger insurance, some of us would stop checking prices before we ordered food, just as we don't check prices when we ask for medical treatment. Some of us would order fancy and expensive foods that we wouldn't order if we really had to balance the price against the improved taste . . . just as we order unnecessary and expensive tests to get just a little more peace of mind.

And if there were hunger insurance, some of us would overeat until we were so round and fat that our health was endangered, just as we see millions of people in America asking for and receiving unnecessary surgery and medication that actually endangers their health.

Effect on Providers

What effect would hunger insurance have on the *providers* of food? Put yourself in the shoes of a grocery store manager. You would start stocking more caviar and less Cheese Whiz, wouldn't you? Rather than

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lose customers to fancier (and more expensive) establishments, you would carpet your aisles, hang chandeliers in the lobbies, and have distinguished-looking fellows with white gloves push people's carts down the aisles!

Every grocery store would offer an impressive array of products, from the very finest meat department to the best stocked liquor counter (providing state law allowed it). That the store next door has the same expensive freezers and wine cellar matters not at all: Cost, you understand, is no object. "Overinvesting in new technology," you ask? Hey, the insurance company pays for it all! And if we don't offer it, customers will cross the street and shop there. You know *you* would.

What if you were a lousy grocery store manager who just couldn't keep costs down and quality up? Before hunger insurance came along, you would be forced out of the market by stores managed by sharper people able to cut costs without sacrificing quality. Customers wouldn't patronize your establishment, and you'd be out of business. But with hunger insurance, you can pass along your higher costs to the insurer, so the customer never knows how inefficient you are! So you get to stay in business despite your inefficiencies. Out of gratitude, you may even spend a little money lobbying to make sure hunger insurance is always available!

If there were such a thing as hunger insurance, the price of food would begin to soar, just as the price of health services has steadily risen faster than the price of other goods and services. Financed by hunger insurance companies, grocers and restaurateurs would sell more food and of a fancier variety than if they faced customers who paid with their own money, just as health-care practitioners today are free to overtreat and overprescribe. Food sellers would overinvest in expensive and under-utilized equipment and pass the cost along to the insurers, just as hospital administrators today buy too many MRIs and CAT scanners and pass along the expense to health insurers. And inefficient, low-quality providers of food would stay in business rather than be forced out by better competitors, just as high-cost providers of health care are tolerated in today's health-care marketplace.

Effect on Insurers

What would happen to *insurers* if hunger insurance were provided? The premiums they charged at first were based on past levels of food consumption and prices. As consumption expands and prices rise, insurers have to raise their premiums again and again. The exploding number of insurance claims buries them in paperwork. The businesses that pay the insurance premiums will, of course, be outraged by all this. "Find a way to control these rising costs!" they will demand. "The rising cost of hunger insurance is making us less competitive with businesses in other countries!"

The insurers will hire an army of "managed-eating" experts who will search the grocery bags of the insured for signs of unnecessary products, just as today's health insurers have hired experts in "managed care" to review health services utilization. People will resent this intrusion into their personal dietary habits, just as they resent the managed care experts second-guessing their health concerns. People with hunger insurance will find ingenious ways to avoid the managed-eating experts, and the eventual results will be higher, not lower spending. . . just as businesses with managed-care programs today are discovering.

Effect on the Uninsured

Some people in our imaginary world will be *uninsured*: They won't have hunger insurance because their employers are too small to afford to offer this new benefit, or because they are self-employed or unemployed. Or, in their effort to control costs and make money, some hunger insurers will refuse to cover people who are high food-risks—the hoarders, the people with exceptionally delicate palates, and the bulimics. They will offer cheaper rates to others: beer-drinking football fans, people who can't smell, and anorexics.

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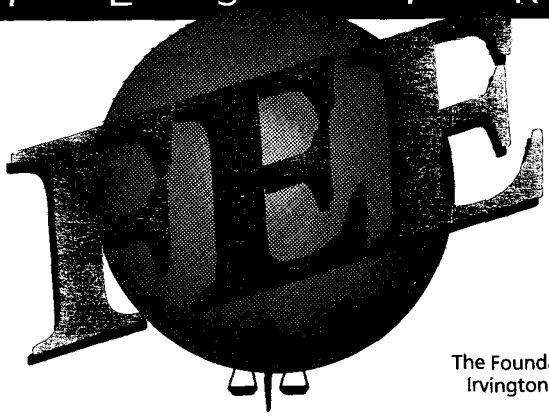

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Class War—American Style

The entitlement society is a conflict society. It breeds social conflict whenever it pursues its basic objective to benefit some people at the expense of others. A simple announcement of a program which is to enrich some and victimize others arouses angry controversies. The beneficiaries rise in defense of the action, the victims denounce it. The beneficiaries may even argue among themselves about their shares of the take, the victims may fight about their respective roles in carrying the burden. There is no social peace, only temporary armistices.

The healthcare proposals that are making headlines today merely resume the old struggle which has marred social relations ever since the days of the New Deal. The outcome will determine who shall reap healthcare benefits and who shall labor to pay for them. But no matter what the final result will be, the legislators and regulators who inaugurate and manage the system will be the primary victors. Ever eager to correct a "problem," solve a "crisis," and end an "abuse," they love a bigger, more powerful apparatus of government.

The new entitlement battle also confirms the old maxim that every act of political intervention makes matters worse which invites ever more radical intervention. One economic law breeds another law, one regulation yet another regulation until production and exchange grind to a halt. In the end, the legislators and regulators who spearheaded the intervention are likely to assume total control. Political intervention breeds comprehensive control, that is, the economic command system.

The American healthcare system is a case in point. Both the Roosevelt and the Truman Administrations failed in their efforts to enact healthcare legislation; the Eisenhower Administration, finally, managed to open the door. It supported the Kerr-Mills Act of 1960 which established a matching grant program offering participating states to bear 50 to 80 percent of the medical costs of needy persons. When this program proved to be unsatisfactory, the Johnson Administration introduced Medicare for the elderly and Medicaid for the needy. When the Medicare system was found to be incomplete, the Reagan Administration added "catastrophic care." When conditions grew from bad to worse and 35 million Americans no longer could afford health insurance, the Clinton Administration rushed into the thick of the fray. With great courage and impeccable logic it demands universal insurance coverage of all Americans. And soon after its proposals will have become the law of the land, the mandated package of basic benefits will be found to be unsatisfactory again. Future laws and regulations undoubtedly will expand the benefits. Indeed, the healthcare war is likely to rage on as long as the people choose to prey on each other.

The Administration's 240-page reform proposal to Congress gives expression to three particular features which characterize

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most entitlement programs. First, the Federal government is to *mandate significant benefit expansion*. Americans will receive "health security cards" that will enable them to claim guaranteed benefits. To name just a few: prescription drugs at nominal costs; extended care in nursing homes or rehabilitation centers; home care as an alternative to hospitalization; hospice care for terminally-ill persons; hospital care in semi-private rooms; mental care through psychotherapy and psychiatric hospital care; medical appliances such as braces, artificial limbs or prosthetic devices; outpatient therapy to restore skills lost from illness or injury; preventive care through immunization, mammogram, prenatal care, and cholesterol screening; substance abuse treatment through outpatient and inpatient services, etc.

It goes without saying that such an expansion of healthcare demand will immediately boost federal spending, increase the budget deficits, and raise wages and prices in all fields hitherto exempt from political care. Many doctors, dentists, nurses, and therapists can expect instant improvements in income and wealth, which in turn is likely to arouse the ire of the sponsors of the system.

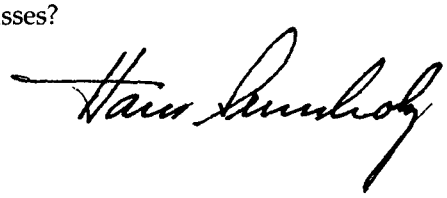
Second, the apparatus of government will assume vast powers over all healthcare providers who must brace for several *new levels of bureaus, agencies, and authorities* sitting in judgment of all matters of healthcare. The proposals call for a seven-member National Health Board (NHB) to be appointed by the President. The Board is to monitor state compliance with all rules and regulations and supervise the functioning of new bureaucratic creations, the health alliances. It will mandate the standard benefit package to which every American will be entitled. It may add new benefits to reflect new technology and new medical needs. The Board will set regional spending ceilings and develop yardsticks and indicators by which it will judge the quality of service and care offered. It will monitor drug prices and object to prices it deems unreasonably expensive. To force compliance with their findings, the seven men and women will apply not only the corrupting power of the federal purse but also the brute power of federal judges.

It is a sad commentary on American public opinion that such concoctions of the bureaucratic mind should actually be debated by our legislators. While governments around the world are turning away from bureaucratization and political omnipotence, our legislators and regulators are urging us to advance by quick march.

Third, *employers are expected to pay the bulk of the costs*. The plan requires them to pay at least 80 percent of the average cost of premiums, and to provide family coverage for married workers. Taxpayers are to subsidize the costs for small and low-wage business and for part-time and unemployed workers.

This vast restructuring of the healthcare system, which is to be phased in over several years, is to control medical costs and provide secure coverage to all. In reality, it will raise federal spending and boost labor costs. Both effects in turn will give rise to more unemployment, which will remain high and move even higher in the coming years until the newly mandated labor costs are reflected in higher healthcare prices and lower take-home wages. In the end, every worker will pay one hundred percent of his insurance costs. It is an old myth that politicians can force employers to grant expensive fringe benefits without reducing the demand for labor; but there cannot be any doubt that legislators have the power to condemn millions of workers to chronic unemployment.

All over the country, a rough debate is about to begin. The basic issue is very clear: should employers be forced by judges and sheriffs to pay part of their employees' premium costs? Should ever more government force be used in the entitlement war of the classes?



Hans F. Sennholz

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You cannot comfort all in distress, nor support all the underprivileged.
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For more information, please contact Dr. Barbara Dodsworth at The Foundation for Economic Education: phone (914) 591-7230 or fax (914) 591-8910.

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Contact Barbara Dodsworth at FEE to enroll or to request additional information.

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The uninsured will be hurt the most by hunger insurance because they will see the price of food bid up and out of reach by those lucky enough to have hunger insurance. The foods that were once plentiful and inexpensive will now be unavailable or high-priced, just as health insurance has replaced inexpensive general practitioners with expensive specialists, and inexpensive but slow-working therapies with expensive but quick surgical procedures.

Those who lack hunger insurance will be seen standing with their noses pressed to the windows of our beautifully carpeted and chandelier-lit grocery stores and restaurants, just as millions of Americans today crowd the emergency rooms of state-of-the-art hospitals whose beds are between one-third and one-quarter empty.

Effect on Elected Officials

What would happen to our *elected officials* if hunger insurance existed? Civil rights activists and well-meaning people without much understanding of economics would campaign against for-profit hunger insurers, denouncing them for being heartless in their discrimination against people with eating disorders. They would condemn them for profiting from the provision of something so fundamental to human life as food. "Food is a right, not a privilege," they would say. "The high administrative costs of the hunger insurers are what is causing the problem. We should abolish private hunger insurance companies and replace them with a single provider of food."

And since experience will have so convincingly shown that the current hunger insurance system is inefficient and unjust, our enlightened elected officials would eventually yield to the public's demands and pass "play or pay," forcing businesses to buy hunger insurance for all their employees, or "national hunger insurance," where government acts as the single payer of all hunger insurance claims.

The nation will face a difficult choice: Either abandon the idea that all food should be paid for by hunger insurance, or impose draconian rationing measures, price controls, and restrictions on new investments in food processing and delivery technologies. If we can judge by what is happening today in the health-care arena, the advocates of rationing will dominate the debate.

Commissions will spring up everywhere to determine whether a carrot is more valuable to the community's welfare than a grape, and a grape more valuable than a banana; just as commissions are being created at this very moment to decide whether capping 1,000 teeth is "worth more" than extending a person's life for one week by kidney dialysis. The issue will be addressed as if justice and virtue, rather than economics and incentives, were at the heart of the issue.

The Lessons

What if there were such a thing as hunger insurance? This little exercise in imagination teaches us quite a bit about why we spend too much on health care. In its simplest form, the lesson is that we rely too much on insurance to pay for our health-care expenses. This reliance makes us poor consumers, encourages health care providers to provide too much, and allows and even encourages inefficiency and waste.

Sometimes things that should be obvious just aren't. Ninety-five percent of all hospital bills, for example, are paid for by private or government insurance. Can the same be said of any other industry? Is it merely coincidence that costs are rising so much more rapidly in health care than in other industries?

The solution to the nation's health-care crisis is not, of course, to abolish health insurance. Health expenses *are* an insurable risk, and because they can be substantial it certainly makes sense for people to buy insurance. But insurance should not be simply *pre-payment for routine medical expenses*. When insurance is used for this purpose, it leads to overuse and all the problems we saw with hunger insurance.

Insurance, instead, should be limited to protecting us from what are now called

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catastrophic risks. We should *self-insure* against small and routine health expenses, and ask our insurance coverage to "kick in" only for large and unpredicted expenses. These are the kinds of expenses true insurance is designed to cover. And because such expenses are only seldom incurred, the administrative costs and paperwork involved with "real" insurance are far less than that involved with insurance as prepayment.

The policy questions, then, are these: How can we wean our nation off its "addiction" to health insurance? And how can we replace insurance provided by an insurance company with *self-insurance* from our own savings? The answers lie in changing a public policy responsible for creating our addiction in the first place.

Medical Savings Accounts

We rely so heavily on insurance to pay our medical bills because the tax code rewards employer-paid insurance and penalizes self-insurance. Employer-paid health insurance premiums are tax-deductible business expenses for our employers, so they don't count as taxable income at the end of the year. Money spent paying medical bills directly, in contrast, is not tax-deductible. We must pay out-of-pocket medical expenses with what is left of our paychecks after Uncle Sam has taken his tax share.

The tax code has a dramatic effect on our decision to buy health insurance, and on the deductibles and copayments our insurance policies contain. Employer and employee Social Security taxes (15.3 percent), federal income taxes (15–36 percent), and state and local income taxes (approximately 8 percent) can reduce one dollar of pre-tax income to 43 cents or less of post-tax income. Paying for health care with post-tax dollars, then, requires earning one dollar to buy 43 cents' worth of service. Having an employer purchase a health insurance policy, on the other hand, means a dollar's worth of earnings buys an entire dollar's worth of insurance.

The way to correct this situation is to follow the path blazed by Individual Retirement Accounts, or IRAs. IRAs encourage us to put away money for retirement by allowing us to deduct the amount of our contributions from our income when calculating our income taxes. *Medical Savings Accounts, or MSAs*, would operate the same way, but money deposited into the accounts could be withdrawn only for *medical* expenses.

By giving the same favorable tax treatment to self-insurance as is now given to employer-paid health insurance, we can begin to break our national addiction to health insurance. Many of us would choose to purchase insurance policies with much higher deductibles—perhaps as high as $4,000 a year—if the premium savings achieved by switching policies were routed into our personal savings account and allowed to accumulate over time.

Two organizations have designed MSA plans that are fair and affordable for all Americans. They are the National Center for Policy Analysis, in Dallas, Texas, and the Council for Affordable Health Care, in Washington, D.C. Several bills now pending in Washington would create MSAs.

Conclusion

Enabling people to self-insure against small and routine medical expenses may not sound as exciting and promising as "national health insurance" or "play or pay." But MSAs offer the best way to control spending *without* life-threatening rationing, ineffectual price controls, and all the other non-solutions being discussed by politicians today.

Our fictitious world with hunger insurance reveals how over-reliance on health insurance is at the very root of our nation's health-care problems. The solution to these problems is not to pass price controls or impose more regulation on health-care providers. All that is required is a change in the tax code encouraging people to pay for their own health care out of personal savings.

Isn't it nice to know that, sometimes, complicated problems really do have simple solutions? □

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THE FREEWAY TO SERFDOM

by Jane M. Orient, M.D.

Wouldn't it be wonderful to have all the medical care you needed or wanted, without ever worrying about the bill?

And wouldn't it be wonderful to drive to work every day without ever paying a toll or stopping at a red light?

The second question usually provokes much more critical thought than the first. Before people vote the money to build a freeway through their downtown, a lot of inconvenient objections are raised.

The first is this: Do we want to tear up the main business district of town?

The idea of "comprehensive health care reform" to "assure universal access" should stimulate the same thought process. To build such a system, you start by destroying the insurance and medical system that we already have.

Remember what happened in 1965. Before Medicare was enacted. The majority of senior citizens had insurance. *After* Medicare, they just had Medicare. Their private insurance policies were all torn up.

At first, that seemed okay, or even wonderful. Everybody seemed to be getting more for less, or even for free. Now, Medicare is bankrupt, and we're just beginning to see the effects of government rationing. It's as if we built an Interstate into every town and hamlet and then stopped repairing the bridges.

When we build a freeway, we don't necessarily destroy all the other roads. In Britain and Germany, private medicine is allowed to coexist with nationalized medicine. But in Canada, it isn't. If you're a Canadian and want something the government isn't willing to pay for, or you want it now instead of three years from now, you have to go to the United States.

A lot of proponents of "universal access" want to close the private escape hatch. They want no other roads—just the freeway. Of course, there may be some back alleys or secret tunnels or special facilities for Congressmen, but those won't provide American-class medical care to ordinary folk.

Some think we don't need other roads if we have a freeway. But remember what a freeway is: a *controlled access road.*

That's what "universal" access means too. Sure you have the "right" to get on the freeway, just as you have the "right" to medical care in Canada (or the "right" to comprehensive care in the U.S. if you belong to a "managed-care" plan). But you can only get on the freeway from the on-ramp. There is no tollgate or stoplight—but the traffic might be backed up for miles and moving imperceptibly.

In Canada, you don't have to pay to get medical care. In fact, you are *not allowed* to

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pay. Once the global budget is reached in Canada, that's it. The on-ramps are closed. It doesn't matter if you have money. Hospital beds are empty for lack of money to pay nurses, and CT scanners sit idle all night for lack of money to pay a technician. But if *some* people are allowed to pay, Canadians fear that *some* people might get better care than others.

(Until recently, this concern did not apply to dog owners. They could buy a CT scan for their dog, but not for themselves.)

American "managed-care" plans—a favorite model for would-be reformers—resemble the Canadian system in that patients don't have to pay at the time of service. (At least, they don't have to pay very much.) But they do have to go through the gatekeeper, who keeps a sharp eye on the budget.

Unlike the people in toll booths on the New Jersey Turnpike, managed-care gatekeepers don't collect the toll. But that doesn't mean that nobody pays.

Even if we abolish payment at the time of service, medical care must still be paid for. The only choice is to pay in advance or to pay later. With government programs, we often borrow money and commit our great-grandchildren to pay.

Another problem with the freeway is that you can only go where the freeway goes. If there's a roadblock at your exit, you can't take that exit.

Countries that promise "universal access" are pretty good at paying for well-baby checks and vaccines and doctor visits for the common cold. Those are exactly the things most people are able to afford for themselves.

The roadblocks are at the exits that lead to the hospital. The global budgeters "contain costs"—ration health care—by denying those things that you *do* need insurance to pay for: heart surgery, radiation treatments for cancer, hip replacements, things like that. Out of "compassion," reformers may open another exit: the one that leads to the cemetery. Do you think it's accidental that euthanasia and "universal access" are on the agenda at the same time? When government gets involved in providing health care, health care must be rationed.

If you want to see reality, don't look at Disneyland. Look at the Santa Ana Freeway. □

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THE CONSEQUENCES OF MANAGED COMPETITION

by Vincent W. Cangello, M.D.

Under managed competition the primary care physician takes complete charge of the patient's health care. The primary care physician is encouraged, and often financially rewarded, to limit and reduce the number of patients he refers to a medical or surgical specialist.

Under managed competition, a female patient, for example, loses her prerogative to see a gynecologist unless she first obtains

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the permission of her primary care physician to make such a visit.

The limiting of referrals, a basic concept of managed health care, is in direct conflict with the structure of American medical education and the medical profession. Such limits can cause primary care physicians—general practitioners—to prescribe care at levels that exceed their knowledge and training. When this occurs, the patient runs the risk of receiving improper care.

Evidence of this was provided by *American Medical News* on September 14, 1992, when it was reported that malpractice lawsuits filed against primary care physicians is on the rise while those against surgical specialists is declining.

Timothy Morse of St. Paul Fire and Marine Insurance Company, which insures 30,000 doctors in 43 states, told *American Medical News* that "Well over 50 percent of our claims made and over 65 percent of all our claims paid are coming from failure to diagnose and improper treatment."

Medical patients should know that the body of medical information facing today's medical students is so immense that it is virtually impossible for any one doctor to become expert and stay abreast of all its advances.

Physicians specialize in order to master a subject, not merely in order to make more money, as they are often accused. Such an accusation fails to show appreciation for and gives no credit to the students who choose to be specialists for the "security of mastery" or for the enjoyment of the work involved.

Americans today want the best care available, regardless of cost and despite any reluctance to reform bad health habits. They will bring suit against the doctor if they don't get it. With that reality in mind, medical students who choose to become primary care physicians are taught to respect the limits of their ability and to seek the benefit of consultation with medical and surgical specialists, without hesitation, whenever necessary.

This basic tenet of the American medical training, which has produced a quality of health care envied throughout the world, is discouraged by the "primary care/gatekeeper" concept of managed competition.

A review of British medical history demonstrates that any reduction of communication between primary care physicians and their consultants leads to the separation and eventual isolation of the primary physicians and guarantees an overall lowering of the quality of health care available to their patients.

Frank Honigsbaum, an American physician, studied these phenomena and wrote in his report "Division in British Medicine" (Kogan Page Ltd., 1979): "To the world outside, the medical profession [in England] appears to form a unitary whole." In reality, however, "Doctors nearly every where are divided into two main classes—General Practitioners and Specialists—and the gap between them grows wider every year. For this, the advances in knowledge are mainly responsible." He emphasized that "It is the ongoing intellectual partnership and exchange of knowledge occurring between the generalists and specialist [the traditional practice in the U.S.] that keeps the quality of medical care at its best."

If this partnership is disturbed, as it was in the British National Health Service, the quality of care diminishes throughout the system, and especially at the primary care level.

A correct diagnosis and proper care at the outset of a patient's illness will do more to reduce the cost of care than any restriction of appropriate consultation. It would be better to err on the side of an unnecessary consultation than not to have one at all. □

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THE COMING FINANCIAL COLLAPSE OF SOCIAL SECURITY

by Peter J. Ferrara

The first officially recognized financial collapse of Social Security occurred in 1977. Government projections at that time showed, and everyone agreed, that without major changes Social Security would be unable to pay all of its promised benefits within a couple of years, with a yawning, continually growing deficit after that time.

Consequently, by the end of the year, Congress and President Carter dramatically increased Social Security taxes and trimmed benefits. Payroll tax rates increased repeatedly through 1990, for a total increase of 30 percent. Moreover, the maximum income to which this tax rate applied was increased sharply from $16,500 at the time, and indexed to increase every year thereafter. Today this maximum taxable income is $57,600.

The American people were assured over and over by President Carter, the Social Security Administration, and the rest of the Washington political establishment that these changes guaranteed the financial soundness of Social Security "for the rest of this century and well into the next one."[1] But by 1980 Social Security was already in deep financial trouble again. The government's annual financial report for the program showed that without a change in the law, the program might not be able to pay its promised benefits as early as 1981.[2]

To address this second financial crisis, a bipartisan commission headed by Alan Greenspan developed a package of tax increases and benefit cuts enacted early in 1983. The truth is that if the economy had continued to perform as it had in the 1970s, with high inflation and periodic sharp recessions, the system would have collapsed again within four years. But price inflation was sharply reduced in the 1980s, and the economy continued to grow for about eight years after 1982 without a recession, and then slid into a relatively shallow slump. Consequently, another quick collapse was avoided.

But Social Security's long-term financial problems are another question. A key strategy of the Greenspan Commission was to develop a large surplus in the Social Security trust funds from 1990 to about 2010, to be used to help finance the retirement of the huge baby boom generation starting after 2010. However, the latest government projections show the expected surplus shrinking into relative insignificance. Moreover, the so-called Social Security trust funds in any event are not a store of financial re-

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serves that can assure the future ability of the program to pay its promised benefits.

Repeated financial crises are an inherent feature of the Social Security system. The Social Security trust funds are essentially a sham that cannot assure future financial security. Today's young workers will never receive the benefits currently promised to them by the program.

An Inherent Problem

Most people seem to imagine that Social Security operates like a traditional fully funded retirement program. In such a system, the tax payments of current workers are saved and invested to finance their own future benefits. As a result, a huge financial reserve is built up sufficient to finance accrued benefits at any point in time. This reserve is used to finance benefits during retirement years, while current workers at that time will be building up their own reserves to finance their own future retirement.

Social Security, by contrast, fundamentally operates on a pay-as-you-go basis. The tax payments of current taxpayers are not saved and invested to finance their own future benefits. Rather, most current tax payments are immediately paid out to finance the benefits for current retirees. Future benefits for present taxpayers are to be paid out of the future tax payments of future workers when today's taxpayers are in retirement. Consequently, large cash reserves to finance benefits are never developed in such a system.

Such a pay-as-you-go system is quite vulnerable to any adverse development that may upset the delicate balance between expected future taxes and expected benefits. If unemployment rises, revenues from the payroll tax will fall from expected levels. If price inflation accelerates, indexed benefit payments will increase faster than expected. If retirees live longer than expected, benefit expenditures will again grow faster than projected. If the birth rate drops, fewer workers will be available to pay promised benefits in the future that are already paid for and relied on by current workers. These and many other possible developments can quickly tip a pay-as-you-go system into financial crisis, leaving it without sufficient funds to pay promised benefits.

None of this is a concern in the first generation under a pay-as-you-go system. When such a system is begun, a full generation of taxpayers begins to pay taxes, but there are no beneficiaries entitled to benefits based on past tax payments. In a fully funded system, these initial tax payments would have to be saved and invested to finance the future benefits of current workers. But, of course, these initial tax payments are not saved and invested under a pay-as-you-go system. Consequently, in the start-up phase of such a system, there is no concern over bankruptcy, or the inability of the program to pay promised benefits. To the contrary, the system is awash in unclaimed funds, and the only issue is how much to pay out in virtually free windfall benefits to early retirees. Since the first retirees pay little or nothing for their benefits, it is easy to pay them only what can be comfortably paid out of the initial incoming revenues. The beneficiaries will be grateful for the windfall benefits they receive.

After the first generation under such a system, however, this situation completely reverses. The retiring generation will then have paid taxes for an entire lifetime and will have built up enormous benefit claims. At this point, there are no more unclaimed surpluses and no more free benefits to pass out. The issue instead becomes whether taxes from current workers will be sufficient to finance promised benefits. If not, then Congress must raise taxes or cut benefits, in stark contrast to the vote-buying spending sprees of the first generation.

During its first 40 years, Social Security was in its start-up phase, and short-term financial solvency was not an issue. Instead, free windfall benefits were paid out to retirees.

But by the mid-1970s, sufficient benefit obligations had accrued to make financing a problem. Adverse economic developments soon developed to tip the system into financial failure. Inflation soared in the 1970s,

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sharply increasing benefit payments indexed to inflation. At the same time, periodic sharp recessions caused unemployment to rise and wage growth to fall, sharply reducing expected revenues. The combination of these economic difficulties caused the first two financial crises of the system described above. The primary cause of the third wave of financial collapse of Social Security, however, will be demographic, as discussed further below.

The Trust Fund Fraud

Even if Social Security attempted to depart from the principle of pure pay-as-you-go financing and developed a substantial trust fund reserve, future benefits would not be any more assured because of the essentially fraudulent nature of the Social Security trust fund system. Any remaining Social Security revenues after benefits are paid are lent to the federal government in return for new, specially issued government bonds which are held by the Social Security trust funds. The federal government then spends the borrowed Social Security revenues on other programs. The Social Security trust funds hold no assets other than these government bonds.

When Social Security revenues are insufficient to finance current benefits, the government bonds held by the trust funds are to be turned into the federal government for the cash needed to finance the benefits. But the government holds no cash or other assets to back up the Social Security bonds. The trust fund assets are claims against the federal government, government IOUs which will have to be financed out of increased federal taxes or increased federal borrowing. In other words, the trust funds are part of the national debt which must be paid when Social Security needs the money.

As a practical matter, these Social Security trust funds are nothing more than a statement of the amount that Social Security is legally authorized to draw from general federal revenues in the future, in addition to payroll tax revenues. Therefore, if the Social Security trust funds hold $1 trillion at some point, that statement even if true, would not mean that the Social Security system is financially sound. Quite to the contrary, it would mean that Social Security would have an additional $1 trillion claim against the taxpayers, in addition to the claim against them for payroll taxes.

Because the Social Security trust funds do not hold any real assets, just a claim against future tax revenues, a growing trust fund by itself does not mean that paying for the retirement of future generations will be any easier economically. It just means that more of this burden will be met out of income taxes and federal borrowing rather than payroll taxes.

The inherent financial problems of Social Security could be successfully addressed if the system were changed so that it accumulates reserves in a fully funded system and those reserves are invested in productive assets in the private sector. But that would require the government to own so much of the private sector through the Social Security trust funds that it would fundamentally change our entire economic system in an unacceptable way. Consequently, financial problems of Social Security can be solved only by shifting to a private system of decentralized investment accounts controlled by workers individually or through voluntarily organized groups.

The Looming Retirement of the Baby Boom Generation

As indicated above, the primary cause of the next foreseeable financial crash of Social Security is a destabilizing demographic problem. The huge baby boom generation is now entering middle age. Around 2010, this huge generation will start to retire, causing Social Security benefit expenditures to rise. This generation will continue to have a major effect on Social Security spending for the following 40 years.

But something has happened to make matters worse. Starting in the early 1960s, after the development of the birth control pill, birth rates in the United States declined precipitously. With the legalization of abor-

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tion in the 1970s, the fertility rate, or lifetime births per woman, fell below 2.0 in the early 1970s. It continued to decline to a low of about 1.7 per woman, eventually stabilizing at these low levels until the end of the 1980s.

As a result, the baby boom was followed by a baby bust. This means that at the same time the huge baby boom generation will be retiring, causing benefit expenditures to soar, the generation of workers that is supposed to finance their retirement payments out of current taxes will be relatively small.

The devastating impact of this demographic double whammy on Social Security is shown by the Social Security Administration's own long-range financial projections. We can examine these projections under the most widely cited intermediate set of assumptions. Table 1 (on the following page) shows the results under these projections if we combine all three trust funds financed by the payroll tax—the Old-Age and Survivors Insurance trust fund (OASI), the Disability Insurance trust fund (DI), and the Hospital Insurance trust fund (HI). These three trust funds together are referred to as the OASDHI trust funds.

With the huge baby boom generation entering its peak-earning middle-age years, and paying Social Security taxes on its earnings, the program should be doing quite well financially right now. Indeed, as indicated previously, the government's plan is for Social Security to depart somewhat from its usual pay-as-you-go policy during this period and accumulate some substantial trust fund "reserves" to help finance the retirement of the boomer generation.

But Table 1 shows that under the "intermediate" assumptions, tax revenues for all three trust funds combined start to fall short of benefit promises in 2005, only twelve years from now. The federal government must cover these deficits by raising taxes, cutting other spending, or increasing the total federal deficit and federal borrowing. Besides tax revenues, the Social Security trust funds receive imputed interest income on their trust fund bonds. But since the federal government must pay the interest on the bonds, which it does by issuing additional bonds to Social Security in the amount of such interest, that interest does not help the government pay its promised Social Security benefits. To finance these benefits, the federal government must come up with the full amount of cash needed to close the deficit between Social Security taxes and Social Security expenditures. Effectively, the Social Security trust funds must begin redeeming some of their bonds for cash to cover these deficits, though counting the additional bonds received for interest each year the total trust fund assets may continue growing for a few more years.

As shown in Table 1, this annual Social Security deficit grows to almost $40 billion per year in constant 1993 dollars by 2010. By 2015, this annual deficit grows to $120 billion in 1993 dollars. By 2020, the annual deficit is an incredible $226.5 billion in 1993 dollars. The federal government again must either raise taxes, cut other spending, or increase the total federal deficit and federal borrowing by these amounts in order to pay all promised Social Security benefits, even before the Social Security trust funds are exhausted. The financial impact of the long-term Social Security financing crisis will start to hit less than a dozen years from now.

But that is not all. The federal government finances about 75 percent of Medicare Part B, also called Supplementary Medical Insurance (SMI), out of general revenues rather than payroll taxes. SMI pays doctors' bills and other health expenses, while Medicare Part A, or Hospital Insurance (HI), which is financed entirely by payroll taxes, provides coverage for hospitalization. Table 1 also shows the projected amount of this general revenue contribution for SMI each year. The federal government must come up with these funds each year as well through either federal taxes, reductions in other spending, or increased government borrowing.

The general revenue contribution this fiscal year for SMI is about $48 billion. But Table 1 shows that by 2005 this will almost double to about $91 billion in constant 1993 dollars. By 2010 the general revenue con-

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Table 1
General Revenues Needed for Social Security and Medicare Before Combined Trust Funds Are Exhausted Intermediate Assumptions

	Annual Deficits Between Tax Revenues and Expenditures for All Social Security Trust Funds Combined (OASDHI) Constant 1993 Dollars (Billions)	Annual General Revenue Subsidies for Medicare Part B Constant 1993 Dollars (Billions)	Total General Revenues Required for Social Security and Medicare Constant 1993 Dollars (Billions)
2005	2.5	90.6	93.1
2006	6.6	95.8	102.4
2007	12.1	100.3	112.4
2008	19.4	104.6	124.0
2009	28.9	108.7	137.6
2010	38.7	112.3	151.0
2011	50.4	119.3	169.7
2012	65.5	125.7	191.2
2013	82.6	131.7	214.3
2014	100.2	137.2	237.4
2015	121.7	142.2	263.9
2016	139.8	149.5	289.3
2017	159.6	156.2	315.8
2018	180.8	162.3	343.1

Source: Calculated from 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (April 3, 1992); 1992 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (April 3, 1992).

tribution for SMI will grow to about $112 billion. Counting the $39 billion deficit in Social Security, this adds up to a total general revenue burden on the Federal government that year to finance all promised Social Security and Medicare benefits of about $150 billion in 1993 dollars. This is again before the Social Security trust funds are even exhausted.

By 2015, this general revenue requirement to pay promised benefits grows to $263.9 billion in constant 1993 dollars. Paying all promised benefits in that year for Social Security and Medicare alone would consequently create a total federal deficit almost as large as today's federal deficit, unless taxes are raised or other spending cut. By 2018, the general revenue drain to pay all promised benefits would grow to $343.1 billion in 1993 dollars.

Counting the imputed interest on the government bonds held by the Social Security trust funds, all three trust funds combined actually hit their peak in nominal dollars in 2011, as shown in Table 2. In constant 1993 dollars, the combined trust fund assets in 2011 would total about $915 billion. Yet, this is only 75 percent more than current Social Security trust fund assets, which will total about $525 billion for all four trust funds combined this year. Moreover, as also shown in Table 2, the projected trust fund assets in 2011 would only be sufficient by themselves to cover about one year and four months of projected Social Security expenditures. Yet, the current Social Security trust assets of $525 billion are sufficient to cover about one year and four months of projected benefit expenditures as well. Therefore, relative to the size of Social Security and the general economy, the total trust fund assets at their nominal peak in 2011 will not be significantly larger than today. Indeed, the largest the trust funds ever grow relative to expenditures under these projections is only one year and nine months worth of expenditures in 2005.

Consequently, the government seems to

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Table 2

Projected Reserves for All Social Security Trust Funds Combined Intermediate Assumptions

	Nominal Dollars (Billions)	Constant 1993 Dollars (Billions)	As a Percent of Annual Social Security Expenditures (OASDHI)
1993	524.3	524.3	133%
1994	596.1	575.3	142%
1995	670.1	622.5	149%
1996	746.7	667.0	155%
1997	825.6	709.2	160%
1998	907.6	749.5	165%
1999	992.1	787.5	169%
2000	1079.0	823.8	172%
2001	1169.1	858.4	174%
2002	1259.8	887.2	175%
2003	1350.4	913.9	176%
2004	1440.9	938.4	176%
2005	1531.9	961.3	177%
2006	1616.3	972.3	172%
2007	1690.8	976.6	168%
2008	1754.5	974.4	162%
2009	1807.0	966.6	157%
2010	1847.6	953.0	151%
2011	1850.2	914.8	139%
2012	1810.6	859.6	125%
2013	1726.2	788.1	110%
2014	1594.3	701.0	95%
2015	1411.9	598.6	79%
2016	1143.6	464.7	59%
2017	785.3	306.4	37%
2018	232.2	87.1	10%
2019*	—	—	—

*Total trust funds combined are exhausted in 2019.

Source: Calculated from 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (April 3, 1992); 1992 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (April 3, 1992).

Table 3

Total Social Security Tax Rates Needed to Finance All Promised Benefits After Trust Funds are Exhausted* (Current Rate is 15.3%) Intermediate Assumptions

2020	20.25%
2025	22.61%
2030	24.47%
2035	25.45%
2040	25.82%
2045	26.02%
2050	26.38%
2055	27.04%
2060	27.86%
2065	28.60%
2070	29.17%

*Assumes continued revenue from Taxation of Social Security benefits and trust any remaining funds needed to pay benefits are raised by insuring payroll tax rates.

Source: Calculated from 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (April 3, 1992).

be failing to accumulate substantially larger Social Security trust funds. In fact, every year the projected growth in Social Security trust fund accumulations is getting smaller and smaller. What was cited as the incredible projected Social Security trust fund surplus a few years ago is now an incredible shrinking Social Security trust fund surplus. Within a few more years, we can expect the projected Social Security trust funds to deteriorate further, making the specter of the financial collapse of Social Security even more immediate.

After 2011, the projected Social Security trust funds decline, as the deficit between taxes and expenditures begins to exceed the annual interest on trust fund bonds paid by the issuance of new bonds. The federal government must continue to raise funds to cover the entire deficit between taxes and expenditures during this period, in the amounts shown in Table 1, effectively redeeming trust fund bonds equal to the entire deficit amount each year.

The total combined trust funds would be exhausted under these projections by 2019. Paying all promised Social Security benefits after that time would require huge payroll tax increases sufficient to close the deficit between taxes and expenditures in the system each year. The necessary tax increases are shown in Table 3. Paying all benefits promised to young workers entering the work force today would require a total Social Security payroll tax rate of about 27 percent, compared to 15.3 percent today. In other words, projected revenues, even under the intermediate assumptions, would be

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sufficient to cover only about half of promised benefits.

So far we have only discussed the "intermediate" projections. We must examine as well the projections under the so-called "pessimistic" assumptions. These assumptions are actually quite plausible. The "intermediate" assumptions assume regular price inflation of 4 percent per year, after a period of ups and downs, while the "pessimistic" assumptions assume regular price inflation of 5 percent per year. The intermediate assumptions similarly assume regular unemployment of 6 percent per year, while the pessimistic assumptions assume unemployment of 7 percent per year. A critical assumption for projected payroll tax revenues is the rate of growth of real wages. The intermediate assumptions assume real wage growth of 1.1 percent per year, while the pessimistic assumptions assume real wage growth of 0.6 percent per year. Actual experience in recent decades has been roughly halfway between these two assumptions.

Another critical assumption for future revenue is the fertility rate or rate of lifetime births per woman. The intermediate assumptions assume an ultimate regular rate of 1.9 while the pessimistic assumptions assume a regular rate of 1.6. Actual experience over the last 20 years has again been generally between these two rates, with experience in most other Western industrialized countries even lower.

Still another major assumption is life expectancy in retirement. The intermediate assumptions assume life expectancy at age 65 grows about 20 percent over the next 75 years. The pessimistic assumptions assume that such life expectancy grows 40 percent for males and 32 percent for females over this period. No one can know for sure, but given the potential developments in high technology medical care and other advances over the next 75 years, the pessimistic assumptions certainly seem quite plausible and may even underestimate the real possibilities. Indeed, from 1940 to 1990, life expectancy at age 65 grew about the same rate for males as assumed in the pessimistic assumptions and at an even faster rate for females.

Under these quite plausible "pessimistic" assumptions, tax revenues for all these trust funds combined start to fall short of benefits in 1996, only three years from now, as shown in Table 4. In that year, the federal government would have to come up with an additional $16.1 billion in 1993 dollars to pay promised benefits. The short-fall grows to $45.9 billion in 2000, and $100 billion in 2006, again in 1993 dollars.

Table 4 also shows that the annual general revenue contribution for SMI would grow to $77.6 billion in 1993 dollars by 2000. Counting the $45.9 billion Social Security deficit in that year, the total general revenue burden on the federal government to finance all promised Social Security benefits is $123.5 billion in today's dollars. By 2006, just over a decade from now, this total general revenue requirement grows to $205.3 billion, again even before the trust funds are exhausted.

All three Social Security trust funds combined actually hit their peak in nominal dollars under these projections in 1999, as shown in Table 5. In constant 1993 dollars, the combined trust funds would total $527.6 billion in 1999, about the same as today. Indeed, the projected total 1999 trust fund assets would be sufficient to cover just over one year of benefit expenditures by themselves, compared to one year and four months for the current trust funds. Consequently, under these projections, the expected Social Security trust fund buildup to help fund the retirement of the baby boom generation never occurs.

The combined trust funds under these projections would be exhausted in 2007—just 14 years from now. Paying all Social Security benefits in 2010 would require an increase in the total Social Security payroll tax rate of about one-third, to about 20 percent from the present 15.3 percent, as shown in Table 6. By 2020, the total Social Security payroll tax rate would have to almost double to about 27 percent. In other words, total Social Security revenues by that date just 17 years from now would only be sufficient to pay about half of all Social Security benefits. In later years, paying all

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Table 4

General Revenues Needed for Social Security and Medicare Before Combined Trust Funds Are Exhausted, "Pessimistic" Assumptions

	Annual Deficits Between Tax Revenues and Expenditures for all Social Security Trust Funds Combined (OASDHI) Constant 1993 Dollars (Billions)	Annual General Revenue Subsidies for Medicare Part D Constant 1993 Dollars (Billions)	Total General Revenues Required for Social Security and Medicare Constant 1993 Dollars (Billions)
1996	16.1	61.3	77.4
1997	20.9	64.5	85.4
1998	27.6	68.7	96.3
1999	36.5	73.0	109.5
2000	45.9	77.6	123.5
2001	54.7	82.1	136.8
2002	62.8	85.8	148.6
2003	71.1	90.5	161.6
2004	80.4	95.2	175.6
2005	89.8	100.6	190.4
2006	100.0	105.3	205.3

Source: Calculated from 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (April 3, 1992); 1992 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (April 3, 1992).

benefits promised to young workers entering the work force today would require a total Social Security payroll tax rate of over 40 percent, an increase of almost three times the current rate of 15.3 percent. In other words, projected Social Security revenues

Table 5

Projected Reserves for All Social Security Trust Funds Combined "Pessimistic" Assumptions

	Nominal Dollars (Billions)	Constant 1993 Dollars (Billions)	As a Percent of Annual Social Security Expenditures (OASDHI)
1993	513.1	513.1	128.0%
1994	574.6	540.0	131.0%
1995	629.9	557.7	131.0%
1996	664.9	561.7	127.0%
1997	694.8	559.0	123.0%
1998	715.7	548.4	116.0%
1999	722.9	527.6	109.0%
2000	713.3	495.7	99.0%
2001	684.8	453.3	88.0%
2002	631.5	396.6	74.0%
2003	551.9	329.8	60.0%
2004	444.7	253.4	45.0%
2005	308.4	167.4	29.0%
2006	121.6	62.8	10.5%
2007*	—	—	—

*Total Trust Funds combined are exhausted in 2007.

Source: Calculated from 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (April 3, 1992); 1992 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (April 3, 1992).

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Table 6
Total Social Security Tax Rates Needed to Finance All Promised Benefits After Trust Funds Are Exhausted* (Current Rate Is 15.3%) "Pessimistic" Assumptions

2010	19.78%
2015	22.97%
2020	26.97%
2025	31.49%
2030	35.52%
2035	38.38%
2040	40.08%
2045	41.21%
2050	42.54%
2055	42.28%
2060	46.33%
2065	48.18%
2070	49.90%

*Assumes continued revenue from Taxation of Social Security benefits and trust any remaining funds needed to pay benefits are raised by insuring payroll tax rates.

Source: Calculated from 1992 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund (April 3, 1992).

under these assumptions would be sufficient to cover only about one third of promised benefits.

But even this is not the worst plausible scenario. Economic performance in the 1990s could be like the 1970s, with unemployment rising and real wages falling behind rapidly rising inflation. At the same time, high-tech medical breakthroughs could rapidly advance old-age life expectancy beyond even the "pessimistic" assumptions, while fertility rates could fall to Western European levels at or below the pessimistic assumptions. Some or all of these quite possible developments would create even more gaping deficits, and require even more draconian tax increases to pay promised benefits.

But tax increases approaching two to three times current levels could never be adopted. Indeed, the current payroll tax is already far too high, seriously hampering economic growth and limiting job opportunities for today's workers. The payroll tax is basically a tax on employment. To the extent it is borne by employers, it discourages them from hiring. To the extent it is borne by workers, it discourages them on the margin from working as much as otherwise. The overall result is fewer jobs, less work, and slower economic growth. Here, as elsewhere, the result of taxing something, in this case employment, is that there is less of it.

Indeed, one study estimated that just the payroll tax rate increases that went into effect in 1988 and 1990, raising the total payroll tax rate from 14.3 percent to 15.3 percent, ultimately eliminated one million jobs and reduced GNP by $25 billion per year.[3] In a society supposedly deeply concerned about employment opportunities, the tax burden the government places on employment is absurd. The debate should be over payroll tax cuts, not increases. In any event, increases of the magnitude necessary to pay promised Social Security benefits in the future are clearly economically and politically infeasible.

As a result, today's workers will never receive the benefits currently promised to them by Social Security, even though they are paying thousands of dollars each year for such promised benefits, and will do so for their entire careers.

Conclusion

The long term financial crisis of Social Security is not the only problem justifying the abolition of the system. The program's payroll taxes are now so high that even if all the promised benefits are somehow paid, these benefits would still represent low, below-market returns, on the thousands of dollars today's young workers must pay into the system each year for their entire careers. For most young workers the benefits would represent a real rate of return of around 1 percent or less, and to many the return would be close to zero, or even below zero. These workers could now receive much higher returns and benefits investing through the private sector. Average-income workers could accumulate over half a million dollars in today's terms by retirement, and more than a million for two-earner

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average-income families, for the same sums now paid into Social Security. This makes the inevitable inability of Social Security to pay even the currently promised inadequate benefits all the more troubling.

The Social Security benefit structure is also rife with inequities, paying some workers much less in returns on their tax dollars than others. Indeed, many workers are forced to pay for benefits under Social Security that they can never even qualify for or receive. Most fundamentally, Social Security deprives workers of the freedom to control the large sums they are now paying into the system each year. The long-term financial problems of Social Security should not be allowed to obscure these many other critical problems.

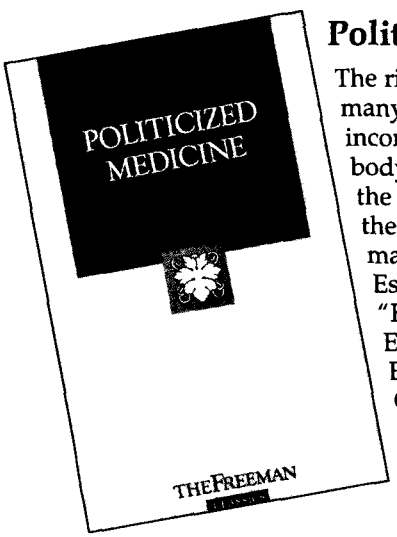
Social Security's financial problems, as well as the other problems discussed above, can ultimately be solved only by shifting to a fully funded system of private savings and investment. Such a system would avoid the inherent vulnerability of pay-as-you-go financing and accumulate a vast reserve of economically productive private sector assets to back up benefits. Through such a system, young workers could also obtain the much higher returns and benefits now available to them through the private market, in the process accumulating large family nest eggs in their retirement accounts. Workers would also have control and freedom of choice over the large sums they would pay into and accumulate in such a system. The same market returns would be available to everyone, and workers could tailor their benefit packages to suit their personal needs and preferences. They would never have to pay for benefits they did not need or could not even qualify for.

Such private systems have been adopted in recent years in Chile and, in part, in Great Britain, and have been broadly popular in both countries. There is no reason why such a system could not be adopted in the United States as well. □

1. This statement was quoted over and over again from the *1978 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds* (Washington, D.C.: U.S. Government Printing Office, May 15, 1977), p. 3.

2. *1980 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund* (Washington, D.C.: U.S. Government Printing Office, June 17, 1980).

3. Aldona and Gary Robbins, *Effects of the 1988 and 1990 Social Security Tax Increases*, Institute for Research on the Economics of Taxation, Economic Report #39, February 3, 1988.



Politicized Medicine

The right to health care services and benefits, which so many are proclaiming today, is merely the right to seize income and wealth from other individuals through the body politic. The essays in *Politicized Medicine* provide the reader with a thorough understanding of why further government intervention into health care will make matters worse.

Essays include: "The Economics of Medical Care," "Free Medicine Can Make You Sick," "Why I Left England," "Socialized Medicine: The Canadian Experience," and "National Health Care: Medicine in Germany, 1918-1945."

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THE FREEMAN
IDEAS ON LIBERTY

THE POLITICS OF THE "FAIR SHARE"

by Gary North

Daniel Patrick Moynihan, U.S. Senator from New York and former Harvard professor, has told the press not to blame Congress for spending too much money, since "we can't do anything about it."

Don't blame those who are leading the nation into a debt disaster? Don't blame them because they cannot stop themselves? Senator Moynihan may have been indulging in verbal playfulness—enhancing his reputation for being a kind of mischievous Irish leprechaun. What he is saying, however, is that those who pass the legislation should not be held politically accountable. Because the voters continue to return these people to office, it appears that the voters agree. Worse, it appears that the voters want more of the same. They may say that they want Congress to stop spending in general, but they are not willing to say that Congress should stop specifically. If voters will not vote in terms of the need to stop spending specifically, their call to stop spending generally has no teeth in it—no political sanctions. The politicians respond only to political rewards and threats. There are no great rewards for spending less on specific projects. On the contrary, there are penalties. The politicians vote accordingly: more spending on specific projects.

Out of Control

If someone is both out of control and is a threat to others, he is supposed to be placed under restraint by the civil authorities. What happens when it is the civil authorities who are out of control? We are seeing the answer to this question. We are eyewitnesses to a looming disaster—a disaster financed by our money and resources.

Political institutions in a free society do not become a threat to the voters overnight. The process takes a long time. Economists prefer to explain the process of decline in terms of incentives: Somehow, destructive behavior is being subsidized. Political scientists explain such defects as products of poorly designed political institutions. Sociologists appeal to broad social forces that pressure politicians to do destructive things. Moralists search for evil intentions on the part of those who hold power. Theologians may go so far as to say that destructive political orders are God's judgment on rebellious societies. Everyone has his favorite explanation. Everyone wants to lay blame somewhere . . . usually somewhere else. Almost everyone wants to evade responsibility. And that is the heart of the problem.

Dr. North is president of The Institute for Christian Economics in Tyler, Texas.

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In the Hearts of the People

In the eighth century B.C., the prophet Isaiah warned the nation of Judah: "How the faithful city has become an harlot! It was full of justice; righteousness lodged in it; but now murderers. Your silver has become dross, your wine mixed with water: Your princes are rebellious, and companions of thieves; every one loves bribes, and follows after rewards. They do not defend the fatherless, nor does the cause of the widow come before them" (Isaiah 1:21–23). But he did not lay the blame solely on the rulers; he laid it on the whole nation: "Alas, sinful nation, a people laden with iniquity, a brood of evildoers, children who are corrupters! They have forsaken the LORD, they have provoked to anger the Holy One of Israel, they are turned away backward" (Isaiah 1:4).

Isaiah recognized that the rulers were representatives of the people. The rulers did evil things because the people in their own lives were also doing evil things. This is not to say that all the people were guilty of rebellion. The prophet Elijah was told that a remnant still existed in Israel: a small group of seven thousand people who had not bowed to Baal (1 Kings 19:18). But the majority of the nation was involved in rebellion. Their political institutions had not preserved the nation from evil.

Friedrich Hayek wrote in 1944 in *The Road to Serfdom* that in a political order that promotes compulsory wealth transfers, the worst people will rise to the top. The lure of power increases when power is concentrated at the top. The ruthlessness required to rise to power in such a power-driven political order will ensure that the worst get on top. He wrote this in the era of Adolf Hitler and Joseph Stalin.

Hayek's critics denied his argument. They denied that it was socialism as such that allowed Hitler and Stalin to come to power. They insisted that other factors must have been involved. But from 1944 to the fall of the Soviet Union in 1991, the worst kept rising to the top in the countries with the most centralized economies.

MATT RICHARD

Friedrich Hayek
(1899–1992)

Hayek blamed the economic system: socialism. The West's socialists blamed the political system: anti-democracy. The Communists blamed counter-revolutionary forces: saboteurs. But almost nobody blamed the people who lived under tyranny.

Long before Lenin appeared on the scene, European intellectuals and politicians had accepted the economic premise of Communism: the need to establish a state that would redistribute wealth from the rich to the poor. It was not some raving liberal or radical who created the modern system of compulsory welfare; it was the conservative German politician, Otto von Bismarck, who did so in the late 1870s. The common people rejoiced, just as Bismarck knew they would. Even today in Germany there are millions of common workers who still believe that Communism at least protected them and their jobs, despite their long-term poverty. The ideal of the welfare state still is dominant in the one society that experienced the nightmare of both National Socialism and International Socialism: Germany.

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The Politics of "Fair Shares"

When a politician speaks of everyone paying his fair share of taxes, he always means the rich should pay a higher percentage of income than the poor. Meanwhile, politicians offer to the middle class—the eligible voters who actually vote—their fair share of the loot that will be stolen from others by means of the ballot box. Almost no one questions the legitimacy of using the ballot box to confiscate the wealth of others. The debate centers around who should pay their fair share—"someone else"—and those who will collect their fair share: "us."

One question is never raised in public: What will be everyone's fair share of judgment when the political theft process produces economic disaster and political revolution? Everyone assumes that disaster can be deferred at least until after the next election. Everyone assumes that the bills will come due later: "Someone else will have to pay them." But eventually, bills come due.

When they do, societies face their moment of truth. As Hayek says, the worst will then be ready to rise to the top. Blame will be placed, but on whom? On which groups? The politics of revenge will be the great temptation. The politics of envy will have a large constituency.

At that point the remnant must be prepared to announce the truth. What is the truth? In the words of cartoonist Walt Kelley's Pogo Possum, "We have met the enemy, and he is us." This is simply an extension of Isaiah's prophetic observation: "All we like sheep have gone astray; we have turned every one to his own way; and the LORD has laid on him the iniquity of us all" (Isaiah 53:6). This must be our confession before we blame the intellectuals and the politicians.

The Culture of Spending

The remnant faces a barrier to this truth in today's pre-crisis political economy. Those who are willing to say no to their fair share are few and far between, especially in the centers of political power. Those who insist on their fair share have the ear of Congress. How did this happen?

James L. Payne has offered a unique and powerful thesis to explain why this has happened. The reason why Congress continues to pass huge spending bills in the face of massive annual deficits, he says, is that Congressmen live in a nearly closed universe in which the vast majority of the people they talk to or hear from want them to spend tax dollars on specific projects. This closed universe is the culture of spending.[1]

Lobbyists in Washington rarely lobby against spending proposals. Constituents rarely write letters opposing specific spending proposals. Colleagues rarely organize major defenses against specific spending proposals. This even includes political liberals who we might think would oppose almost all military spending. Hearing nothing else, most politicians eventually learn to play their favorite instruments in this symphony of spending.

If this thesis is correct, Payne says, then the longer a politician stays in Washington, the more consistently he will vote for spending. He will be assimilated into the culture of spending. Payne offers statistical evidence to show that this is exactly what happens.

Payne argues that the culture of spending rests on two assumptions: the presumption of government efficiency and the philanthropic fallacy. It is presumed by almost everyone that the civil government can and should use its monopolistic coercive powers to "make things better" by imposing negative sanctions (taxes) on certain groups in order to grant positive sanctions (benefits) to other groups. This is the underlying theoretical assumption of the politics of the fair share.

Three-quarters of all government spending now goes to the purchase of personal goods and services that individuals could buy for themselves, not the purchase of usual public goods: police, courts, roads, etc. Citizens who oppose such wealth transfers are regarded as opponents of the public good, when in fact they are merely trying to retain more of their own wealth to do for

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themselves what civil government plans to do for them, minus 50 percent for handling (approximately what it costs the government to administer its programs).

Just about every special interest wants more spending. Politicians find ways to give this to them. The culture of spending rolls on. Writes Rupert Penmant-Rea, the retiring editor of the 150-year-old British weekly magazine, *The Economist*: "If lobbying has a shrine, it is in Washington, D.C. No self-respecting lobbyist can feel his career is fulfilled until he has made the pilgrimage there, and mastered the rites of the priesthood. There are about 80,000 lobbyists in Washington, twice as many as ten years ago. They even have their own American League of Lobbyists, which I hope is a deliberate parody."

But this phenomenon is not strictly American. "In all Western democracies," he says, "lobbying has long since become a mature industry." In early days, lobbyists asked for more specific spending and specific tax relief. But in the 1970s, everyone got into the game. Then the taxpayers started to complain. The politicians turned to borrowing and inflating the currency. "More spending, more taxes, more borrowing, more inflation: each stage of the sequence damaged general economic welfare while benefiting the organized rowdies." Today, he believes, the special interests are facing governments that have run out of resources. He predicts that governments will now turn to that age-old favorite: protectionism.[2] This will reduce almost everyone's wealth.

The False Morality of the Welfare State

Every culture rests on moral presuppositions. The culture of state spending rests on a false one: the widespread belief that the state is a morally legitimate instrument of coercive wealth redistribution. Until this moral presupposition is abandoned by most voters—a moral conversion which may have to be stimulated by the attention-getting occurrence of national bankruptcy (deflationary or inflationary)—there are no believable technical solutions to the culture of spending. Technical political solutions are necessary but not sufficient for overcoming the culture of spending, which is a religiously grounded viewpoint. This deeply religious impulse is made clear in Jack Douglas' monumental book, *The Myth of the Welfare State*, which should be a companion volume to *The Culture of Spending*.

In a society in which a majority of voters accept the role of the state as a source of wealth redistribution as morally valid, there will be widespread negative consequences. Politically, voluntary cooperation will be replaced by interest-group politics and the confiscation of private wealth. The worst will begin to rise to the top. This will eventually lead to an economic crisis and a loss of confidence in the prevailing social order. It is then that principled men must say no to the politics of the fair share. They must be ready to present both a moral critique of the culture of spending and a technical critique. It is not enough to show enraged, envy-driven voters that the welfare state has failed to deliver the goods. Voters must be reminded that their own false morality has led them into a crisis, and that repentance—a change of mind—is necessary for social healing. The culture of spending must be shown to be the moral low ground, not just an inefficient solution to the problem of scarcity. □

1. See James L. Payne, *The Culture of Spending* (San Francisco: ICS Press, 1991).

2. "An editor's farewell," *The Economist* (March 27, 1993), p. 17.

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BOOKS

Social Security: What Every Taxpayer Should Know

by A. Haeworth Robertson

Retirement Policy Institute, Washington, D.C.
Order from: Retirement Policy Institute, Publications Division, P.O. Box 240242, Charlotte, NC 28224 • 1992 • 321 pages
$40.00 cloth; $14.95 paperback

Reviewed by John Attarian

Misunderstandings surrounding Social Security are on a scale comparable to its size and impact on our national life. Millions of Americans believe that they only recover in benefits what they paid in taxes; that their taxes are "invested" in a "trust fund" accumulating assets to pay "insurance"; that benefits are "bought and paid for," an "earned right" which is "guaranteed." This misunderstanding, "the most serious threat to Social Security in the immediate future," prompted A. Haeworth Robertson, Chief Actuary of Social Security from 1975 to 1978, to produce an excellent handbook for taxpayers.

In clear, readable text, assisted with numerous helpful charts and tables, Robertson first describes the basics of Social Security —the benefit system, costs, the payroll tax system, and the two basic methods for financing Social Security: current-cost financing ("pay-as-you-go"), whereby current taxes pay current benefits; and advance payment, whereby current taxes accumulate a large trust fund to pay future benefits. The next 17 chapters address selected topics, e.g., actuarial assumptions, inflation and cost of living adjustments, how Social Security determines behavior, and Medicare.

Robertson masterfully describes two key measures of Social Security's financial condition, "actuarial deficits" and "accrued liabilities," often confused in the public mind. "Actuarial deficits" are the excess of projected future costs over projected future income. Social Security's total actuarial deficit, including Medicare, is an eye-popping $13.2 trillion over the next 75 years. "Only the foolhardy would continue to ignore the longer range financial problems projected for the Social Security program. . . . It is a question of whether we are making promises we will not be able to keep."

"Accrued liabilities" are the present value of future benefits which have accrued as of a certain date. As of January 1, 1990, Social Security's unfunded accrued liabilities were $12 trillion. That is, "we have made promises worth $12 trillion more than we have collected in taxes [to honor them]."

The situation is even bleaker than Robertson reports. The 1990 annual report of Social Security's Board of Trustees, which he consulted, predicted exhaustion of Social Security's trust funds in 2043 (2023 under pessimistic assumptions); 1993's report projects exhaustion sooner: in 2036 (pessimistically, in 2017). Medicare's 1993 report projects trust fund exhaustion in 1999 (pessimistically, in 1998).

Social Security's looming financial crisis is rooted in demographics. As the huge baby-boom generation retires, Social Security's costs will soar, but our falling fertility rate means fewer and fewer taxpaying workers will support each beneficiary. Thus the enormous actuarial deficits. "Unfortunately these long-term projections and their significance do not appear to be widely known and understood by the public or the Congress or the Administration."

Social Security is widely misunderstood partly because its low initial cost fostered complacency. Also, being poorly informed about the program, the media misleads the public. And government use of insurance terminology ("trust fund," "contribution," etc.) creates a false impression of Social Security's nature. Hence, government and public alike take an unacceptable "head in the sand" approach.

For example, the Supplementary Medical Insurance program myopically estimates costs only three years ahead. And in a valuable discussion of the actuarial assumptions about our future fertility rate, produc-

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tivity, and death rate which the Social Security Administration uses to project Social Security's future status, Robertson cogently argues that the SSA's assumptions are too optimistic, and that pessimistic projections should be used, to avoid unforeseen negative developments.

Discussing Medicare, Robertson acknowledges that the "third party payer" principle contributed heavily to our soaring health care costs by destroying incentives for cost control, and cautions against national health insurance: "it is questionable whether there is anything inherent in a nationally designed and managed system that would not also work in a decentralized, free-enterprise system . . . . If individual freedom of choice is relinquished to attain a uniform social insurance structure, it may soon be relinquished in other areas of life as well."

Social Security's march to the abyss prompts the thought that dismantling it would be the wisest policy. Unfortunately (if understandably), Robertson asserts that abolishing Social Security is "out of the question," that social insurance is "absolutely necessary" in modern society. He does call for change, which might entail a separate scheme for young people.

Also, Robertson inadvertently illustrates the philosophical muddle of America's welfare state. He argues that Social Security will give us our money's worth if designed on the principles of maximum individual freedom of choice consistent with the national interest, maximum individual opportunity and incentive, and government provision of only those benefits an individual cannot provide for himself. Yet he also contends that "Social Security is a program of social insurance. It emphasizes social adequacy. It pays benefits according to presumed need," and that in such a program "no attempt is made" to relate a given group's benefits to the taxes it paid to qualify for them. That this is an admission that America's largest welfare program applies the evil Marxist principle "From each according to his ability, to each according to his need," escapes his notice.

Nevertheless, *Social Security*'s merits outweigh these flaws. Its thoroughness, accessibility, and comprehensiveness make it indispensable for everyone concerned about Social Security, including opponents.

Best of all, Robertson is unflinchingly honest. He repeatedly warns taxpayers that they face substantially higher taxes unless Social Security is radically altered; that the notion of entitlement is dangerous; that misunderstandings about Social Security are abetting an "alarming" decline in a sense of responsibility for oneself; that future costs will probably exceed the SSA's "most likely" projections; that general revenue financing would encourage disregard for the future; and that "It is clearly inappropriate . . . to rely upon some undefined good fortune to enable us to continue our present Social Security program without paying substantially higher costs." He emerges as a believer in Social Security haunted by a vivid awareness of its costs and perils, and blessed with an honest man's determination not to disserve his reader by minimizing them. After so much calculated deceit in federal budget policy in recent years, Robertson's courage and candor are just what the doctor ordered. □

John Attarian is a free-lance writer in Ann Arbor, Michigan with a Ph.D in economics, and an adjunct scholar with the Midland, Michigan-based Mackinac Center for Public Policy.

Mises: An Annotated Bibliography: A Comprehensive Listing of Books and Articles by and About Ludwig von Mises

Compiled by Bettina Bien Greaves and Robert W. McGee

The Foundation for Economic Education, Inc., 1993 • 408 pages • $29.95

Reviewed by Israel M. Kirzner

This is, quite simply, an extraordinary work. The reference, in its title, to an "annotated bibliography," is grossly, al-

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most laughably, inadequate as a description of it. Even its subtitle fails to convey its phenomenal and fascinating scope. This book not only provides a "comprehensive listing" of relevant material; it provides in most cases, excerpts from, or succinct characterizations of, the material referred to. This has resulted in an encyclopedic treasurehouse of materials and information regarding Mises, his works, and the reactions of hundreds upon hundreds of reviewers and authors to his ideas and his writings. Dozens of future doctoral dissertations could be planned based on the wealth of information and bibliographical citations included here, covering sources spanning some 80 years and translated from many languages. As a bibliographical compilation this is utterly unique. Its compilers richly deserve doctorates of their own for the scholarship and indefatigable research which this work so obviously reflects.

Some of the material included here (for example, the full translations of a number of the reviews—including one by Knut Wicksell—of Mises' 1912 first German edition of *The Theory of Money and Credit*) will be extremely valuable for the historian of economic thought. Many of the excerpted reviews of the early editions of Mises' *Socialism* provide fascinating insights into the interwar mentality on the topic. It is certainly not surprising to read that as ardent a socialist as Harold Laski described Mises' book as an "extravagant and often ignorant diatribe" (p. 162). It *is* an eye-opener to read that as eminent an economist as Frank Knight dismissed the entire debate concerning economic calculation as "largely sound and fury," declaring that "Socialism is a political problem . . . and economic theory has relatively little to say about it" (p. 162). Some of the material provides arresting (often wry) commentary on personal aspects of Mises and his relations with other scholars. For example, one reads (on p. 253) with a certain fascination, University of Vienna Professor Hans Mayer's tribute to Mises on his 70th birthday, bearing in mind Mises' own description of Mayer as having preoccupied himself, during Mises' years at the University of Vienna "with mischievous intrigues against me (*Notes and Recollections*, p. 94)." Among so many thousands of pieces of information—the index contains more than 2,500 entries—certain parallels and contrasts pop out, adding to the interest of the volume. (As an example: A passage cited [on p. 322] from a German-language 1974 book by Engel-Janosi concerning Mises' openness in his famed *Privatseminar*, to the articulation of opposing views, seems to be a *verbatim* parallel to a 1973 German-language newspaper article by M. Steffy Browne, cited on p. 311.)

If the bibliography of Mises' own works is spectacularly exhaustive (going far beyond that outstandingly valuable earlier bibliography compiled by Bettina Bien Greaves and published by The Foundation for Economic Education in 1970), it is the "listing" of books and articles *about* Mises (going only up to 1982—while the book reviews include items from later years) which is most extraordinary. Certainly no economist has ever before been accorded this kind of attention. Listed are not only books and articles about Mises, but books and articles in which the *slightest* reference to Mises is made. One can only marvel at the detective work that must have gone into the tracking down of such references in unpublished doctoral dissertations (as on pp. 325, 332, 349, 355, 371), in the autobiography of a priest (p. 347), in a letter to *Business Week* (p. 324), or in a 1981 Spanish-language Buenos Aires article arguing that Mises' views do not contradict those of Aquinas (p. 381).

I would be less than candid if I did not register my fear that the inclusion of many references (for example those to somewhat repetitious laudatory assessments of Mises at special commemorative occasions, or those to rather trivial comments, or those which appeared in obscure, ephemeral publications) may lead the critical outside reader to dismiss the entire volume as a pious exercise in hagiography. This would be most unfortunate and quite unfair. Although the inspiring and utterly splendid loyalty of Bettina Bien Greaves to Ludwig

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von Mises shines through this work, she and Professor McGee have bent over backwards to include the negative (often outrageous!) comments of the critics of Mises, as well as the praise of Mises' admirers. Certainly this work valuably records the reactions of hundreds of writers to the work of Mises, the champion of liberty. But its lasting scholarly value lies in its being an important, objective, and remarkably researched source concerning Mises, the eminent economic theorist.

I confidently expect that many of us will be consulting this wonderful volume again and again. Bettina Bien Greaves, Robert McGee, and The Foundation for Economic Education are to be warmly congratulated on this valuable contribution to the growing Mises literature. As the value of Mises' own contributions to economic understanding will come to be more and more widely recognized in the years to come, the significance of the patient and dedicated research which culminated in this work will be sure to increase correspondingly—and to be correspondingly appreciated. □

Dr. Kirzner is Professor of Economics at New York University.

The Ruling Class: Inside the Imperial Congress

by Eric Felten

The Heritage Foundation, 214 Massachusetts Avenue, N.E., Washington, DC 20002
222 pages • $24.00 cloth; $2.95 abridged paperback edition

Reviewed by Peter F. Steele

The Ruling Class: Inside the Imperial Congress is a definitive study of the workings of the late twentieth-century federal government using Congress as the focal point. It is very successful in its description of a byzantine Congress and its schemes and "scams." It is an ideal companion to Martin L. Gross' *The Government Racket: Washington Waste From A to Z* since it provides a window to the wasteful programs and pork barrel projects born in a Congress bent upon creating a "Barnumoconomy" in a "Barnumocracy."

Probably the most cogent evidence Felten's work provides is that many Congressmen have truly abdicated their responsibilities as legislators while avoiding accountability for the laws made and the positions taken.

Chapters one through eight, respectively titled as "Sleight of Hand," "The Bullies' Pulpit," "Legislating Backwards," "Staff Infection," "The Grand Inquisitors," "Other People's Money," "Not-So-Innocents Abroad," and "The Re-election Machine," all define the present system, contradictory to the limited and fair government originally propounded by our Founding Fathers after the American Revolution. Chapter nine enumerates helpful suggestions for honest reforms in Congress. Those in our society and government who do care about matters across political, economic, and social lines would find the material in this chapter worth the cost of the book. □

Mr. Steele is a free-lance writer from Stamford, Connecticut.

Prosperity Versus Planning: How Government Stifles Economic Growth

by David Osterfeld

Oxford University Press • 285 pages • $39.95 cloth; $19.95 paperback

Reviewed by William H. Peterson

David Osterfeld in his *Prosperity Versus Planning*, a scholarly and most worthwhile book supported by the Cato Institute, argues on both theoretical and empirical grounds that government planning and economic growth don't mix, that the interventionist paradigm spells planned chaos, that it is deadly to development at home and abroad, that, again, it is wiser to work with than flout the law of opportunity cost.

Professor Osterfeld accordingly sees foreign aid as mainly counterproductive to

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Third World development, underwriting as it does entrenched governments which soon detect a way to maintain power and accumulate private wealth in Switzerland and other havens for "hot money." He cites the work of Lord Peter Bauer and African economist George Ayittey on how foreign aid has grievously set back African and other development. And he sees that attacks in the United Nations and elsewhere on foreign investment and multinational corporations are blind to the benefits of private foreign investment, technology transfers, and job creation in viable Third World industries competing in world markets.

He especially excoriates both the U.N.'s Brandt Commission Report, *North-South: A Program for Survival*, and the United Nations Code of Conduct on the Transfer of Technology adopted in the early 1980s. These documents condemn "market failure" and recommend government-to-government assistance along with Third World interventionism in such forms as government regulation, price controls, and state-owned enterprises so to control what the United Nations regards as inappropriate technology. Said the Brandt Report, for example: "The poorer and weaker countries have not been able to raise much money on commercial terms. For them, Official Development Assistance or aid is the principal source of funds . . . . An increase in total aid must remain a high priority . . . . The overall flow of wealth must increase . . . . The overwhelming proportion of aid money has been usefully spent [and has] done much to diminish hardships in low-income countries."

Professor Osterfeld rejects these tenets as untrue and holds the free market and not government intervention is a much more effective and far less costly method of regulation. Here he stresses the role of economic calculation in explaining why state-owned enterprises and central planning in general are doomed to failure. Economic calculation, based on free markets, perceived opportunity costs, and private property rights, permits the price system including interest rates to best "regulate," i.e. allocate, goods and other scarce resources to their most urgently desired applications. Economic calculation is at the center of economic development, the very secret of the North's long-time economic success and perhaps of Western Civilization itself.

The plight of the interventionists and socialists, notwithstanding elaborate planning boards and Five-Year Plans, is that without the benefit of economic calculation they are flying blind, that they are the bland leading the bland. And hence they are wide open to corruptible temptation and perverse political pressures. Osterfeld quotes Mises: "No single man can ever master all the possibilities of production, innumerable as they are, as to be in a position to make straightaway evident judgments of value without the aid of some system of computation."

Amen. □

Dr. Peterson is an adjunct scholar at the Heritage Foundation and a contributing editor of The Freeman.

As we prepared final proofs for this issue, we learned of the sudden death of Dr. David Osterfeld on September 26, 1993, at age 43. Dr. Osterfeld was a professor of political science at St. Joseph's College, Rensselaer, Indiana, and an adjunct scholar at the Heritage Foundation.

David Osterfeld's first Freeman *article was published in 1972 while he was a graduate student at the University of Cincinnati. Over the years he contributed more than a dozen articles—all carefully researched, meticulously documented, cogently written. His September 1993* Freeman *essay, "Overpopulation: The Perennial Myth," was reprinted in* Man and Nature, *FEE's recently published anthology on environmental issues.*

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